VOLUME 39
NUMBER 2

FEBRUARY
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THE CANADIAN NURSE

In a Canadian Military Hospital Overseas

See page 96

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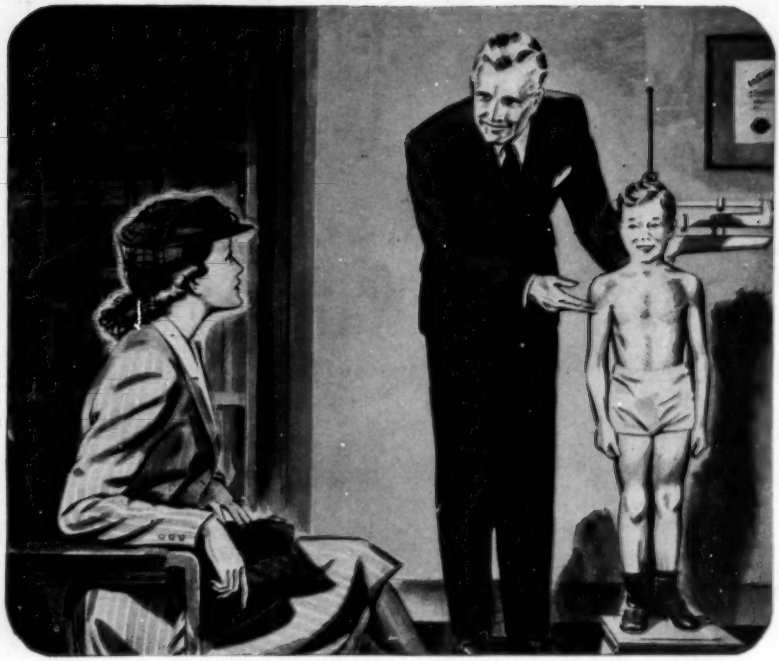

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1938, J. Am. Med. Assn. 110, 650
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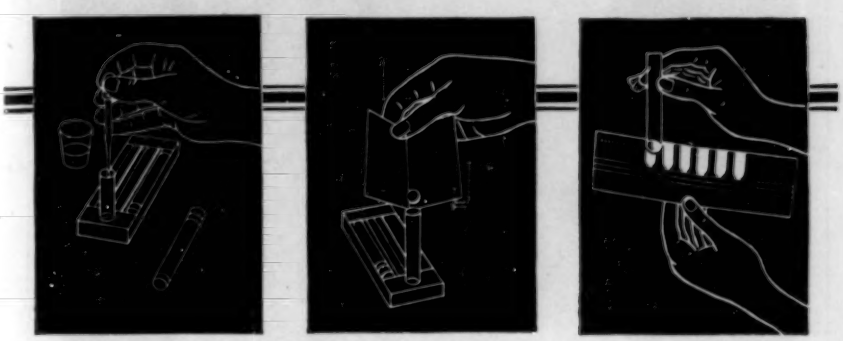

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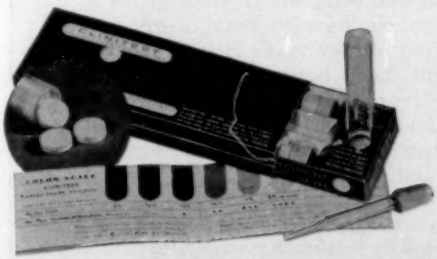

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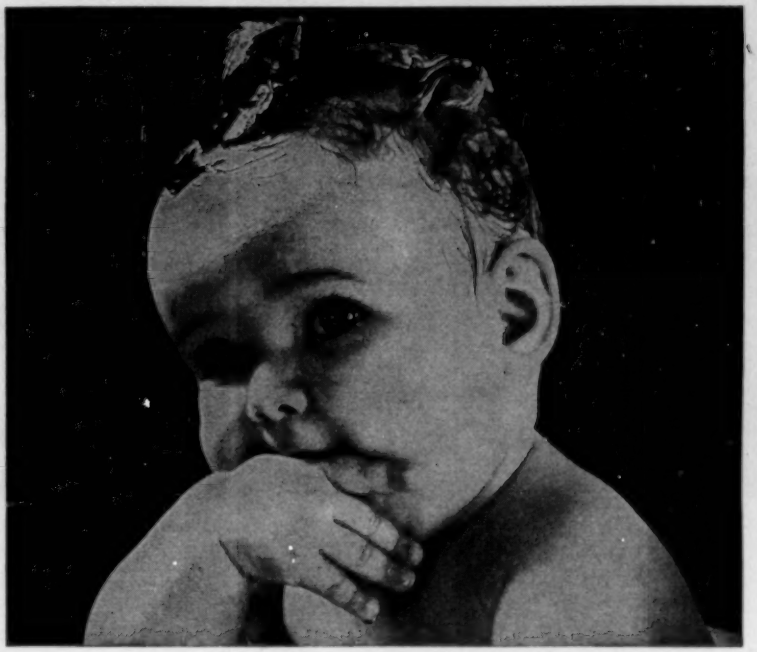

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The Canadian Nurse

Registered at Ottawa, Canada, as second class matter.
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Reader's Guide

The *Journal* is proud to have the privilege of publishing two articles written by **Nursing Sister Alfreda Dearden** and **Nursing Sister D. A. Macham** both of whom are serving overseas with the Royal Canadian Army Medical Corps. These articles were forwarded to the *Journal* by Lieut.-Col. Stuart Gordon, R.C.A.M.C., Officer Commanding No. 1 Canadian Plastic and Jaw Surgery Unit.

We are deeply indebted to Dr. John C. Mackenzie, General Superintendent, The Montreal General Hospital, for permission to publish the photograph which appears on the cover under the caption of "In a Canadian Military Hospital Overseas".

Under the caption of **Reaction to Publicity** the Emergency Nursing Adviser, Kathleen W. Ellis, describes the publicity programme which, for the first time in its history, the Canadian Nurses Association has undertaken. In our Canadian newspapers and periodicals, over the radio, and by means of posters, leaflets and booklets, we are trying to tell our fellow citizens what nursing is all about. We can all help by drawing the attention of our friends to this campaign and, above all, we must be ready to give apt answers to the pointed questions that may be put to us.

It so happens that this issue of the *Journal* contains vivid (but very modest) descriptions of how two widely separated Canadian hospitals dealt with serious emergencies. **Helen MacKay** relates what happened at the Royal Inland Hospital, Kamloops, and **Gertrude Ferguson** tells of a similar experience at the Ottawa Civic Hospital. There is something reassuring about both these statements and they reflect great credit upon the hospitals concerned. Efficiency, calmness and devotion on the part of the nursing staff shine out between the lines.

It is quite apparent that **Florence Erickson** thoroughly enjoys the adventures which come as part of her day's work when she travels along the Pacific coast. Miss Erickson has had considerable experience in public health nursing and, for the past five years, has been associated with the Division of Tuberculosis Control of the Provincial Board of Health in British Columbia.

In her daily work as a member of the staff of the Victorian Order of Nurses **Christine Charter** is able to judge at first hand how the war is affecting family life in Canada.

Now as never before, there is need for knowledge and good judgment in the selection and purchase of special diets. **Nan Garvock** is the dietitian in charge of the Montreal Diet Dispensary and is an authority on this important subject.

Two articles in this issue of the *Journal* deal with the nursing situation in China. "Adventure in Canton" was written by **Thelma Chong** and describes her war experiences in her native land. Miss Chong is a graduate of the School of Nursing of the University of California Hospital and, at the time the article was written, was a member of the nursing staff of the Vancouver General Hospital. Extracts from a personal letter from **Clara Preston** give an interesting sidelight on conditions in Chungking. Miss Preston has been engaged in mission work in China for several years.

Myasthenia gravis is relatively a rare disease and, as pointed out by **B. Dexter** and **C. Kwong**, requires skilled and intelligent nursing care. Both authors are members of the nursing staff of the Vancouver General Hospital.

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†LEPORE, M. J., and GOLDEN, R.: A Syndrome Due to Deficiency of the Vitamin B Complex, J.A.M.A. 117:918-923 (Sept. 13), 1941.

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The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION
VOLUME THIRTY-NINE NUMBER TWO

FEBRUARY 1943

Something to Show for it

Nursing organizations are so accustomed to making bricks without straw that, when funds are unexpectedly put at their disposal, they don't always know what to do with them. The first impulse usually is to make sure that "there is something to show for it". This reaction invariably took place in various nursing enterprizes in Central Europe when, several years ago, grants of money were made available by American foundations. It was interesting to watch the successive stages through which the directors of nursing passed. First came a stage of exhilaration in which everything seemed possible and the sky was the limit. There must be "something to show for it", such as a beautiful and dignified school building, or an elaborate educational demonstration. But there was always a catch in it. How were these projects to be kept going after they got started unless there was an endowment fund or a guarantee of Government aid? Since neither of these were easy to come by, the blue prints were reluctantly put aside and the elaborate demonstration shelved.

Then another possibility would be explored: an investment in human values. Capable teachers and supervisors were badly needed and this money could be used to prepare them. These nurses were selected with the greatest care, and in relation to the jobs they were to do. The experience and instruction provided for them were planned by people who had first-hand knowledge of the working environment from which they came and to which they were to return. Inevitably there were a few failures and misfits but, broadly speaking, the results were excellent. The contribution these women have made to the development of nursing service and education in their respective countries is amazing.

This experience in Central Europe has a definite bearing on the present situation in Canada. We too want to have "something to show for it" but

are forced to admit that while it is easy to launch an elaborate project, it is frequently impossible to keep it going under its own steam. Unless continuing government aid is assured, endowment is the only guarantee and this means a capital reserve of astronomical proportions. The endowment fund of a single school of nursing in the United States is more than a million dollars. Yet the income derived from it must be administered with the greatest care in order to make ends meet.

It is obvious that the total Canadian Government grant, amounting to $115,000 for the current fiscal year, is not sufficient to initiate a single large scale national enterprize, let alone maintain it. Nevertheless, this timely and generous gift is being invested to good advantage. We, too, are investing in human values and some of this money is being spent to build up competent staffs for schools of nursing and public health organizations. When the women thus prepared for leadership buckle down to their respective jobs we shall be able to prove to our Canadian Government that we can spend public money wisely, and that we "have something to show for it".

The Psychoneuroses in Wartime

Editor's Note: With the kind permission of the *Canadian Medical Association Journal*, the following excerpts are quoted from the Address in Medicine delivered by Dr. Alvin T. Mathers at the twelfth annual meeting of the Royal College of Physicians and Surgeons of Canada. The full text appears in the August 1942 issue of the *Canadian Medical Association Journal*.

All will agree that the discussion of such a subject as the psychoneuroses in wartime is timely. I am sure however that before modifications incident to temporal events are considered we must first establish something resembling an orderly conception of the main theme. The noble achievements of Vesalius in anatomy, Harvey in physiology, Virchow in pathology deserve all praise. But in so far as these set going a current of stark materialism that still runs strong, influencing medical education and thought unduly, they perhaps failed of being as great as they might have been. Now we must turn back to the oneness of the Greeks. We must strive to see life and its phenomena, good or ill, whole, and to maintain a reasonable balance between the physical, the chemical and the psychological.

All of us recall how during the last war sheer pressure of events obliged a modification in the strictly materialistic viewpoint then at its very peak. Things that happened then could not be explained by previously held theories. A staggering number of casualties that occurred could only be explained and dealt with psychologically. There came a sharp resurgence, a new birth one might say, of the psychological viewpoint throughout the whole field of Medicine. But gains made were not maintained. Vagueness in concepts, confusion of theories, unfamiliar language and extravagant claims exacted the inevitable toll and a promising development, while

it did not die, dwindled and lost ground. In the intervening years, honest attempts at the establishment of a sane and sober balance were made. And now war has apparently started a new wave of interest and enthusiasm.

The answer to the question "What are the Psychoneuroses?" would at present be different, and radically different, depending on the one to whom it was directed. To the "hard boiled", impatient, and incredulous, the term is practically synonymous with malingering, and carries with it a distinct implication of dishonesty.

To those of strongly materialistic viewpoint the concept is but a step away from the one just mentioned. Nurtured in the belief that any symptom must be traceable to structural or physiological alteration, they pass over as inconsequential or even non-existent, the viewpoint of man as unitary, consisting of superlative mechanism plus some as yet intangible integrating factor, in itself vulnerable and subject to assault and disturbance from such things as emotion, frustration, and latent hostility.

The laity are just beginning to be aware of the term psychoneurosis or neurosis. With them it has not as yet a fraction of the social value that the designation "nervous breakdown" possesses. This seems to be a most useful term, almost certain to call forth from friends and acquaintances a proper and satisfying mystification and sympathy. But with these people also, the materialistic viewpoint is much to the fore. What more natural than to ascribe palpitation to a diseased heart, or digestive symptoms even of vague type to the organ commonly believed to be *the* digestive organ—the stomach? For them their symptoms constitute their disease. When they present themselves before their physician they expect to hear news of organic disorder. That a chronic anxiety may be the cause of a disturbance of heart rhythm or a lasting conflict with some aspect of life the cause of disturbed digestion never occurs to them. And, in fact, they may be incredulous or even hostile when full investigation leaves no other explanation. To stamp their cherished ills as imaginary only rouses resentment and, perhaps to some extent, rightly, since they really are not imaginary. Ascribed to the wrong causes, no doubt, but not imaginary.

For each and all of us, life consists of constant need for compromise. On one side the individual with such constitutional equipment as he has plus his self-centred, not always fully conscious aspirations and urges; and on the other the constant restraining and modifying influence of that individual's world as it is, using the term "world" as highly inclusive. Each individual's world differs from that of any other and so the means and ends of compromise and also the evidences of failure must inevitably differ. As we progress through life, various things in Nature and nurture aid, delay or injuriously modify the much-needed compromise. Such agencies are constantly changing even from day to day. The world is full of people who in the face of this difficult task sense their uneasiness—often without knowing from whence it comes—just knowing that in some way life is not right. All too often with such vague, ill understood but plainly appreciable distress, there is an effort to identify the troubles and perhaps modify them in the form of seemingly physical complaints. And it is the failure in properly elucidating these seemingly physical complaints that leads to serious misunderstanding and inadequate treatment of the underlying psychoneurosis.

In the psychoneuroses there is no question of other than a unitary response. It is the whole individual, his psycho-

physico-chemical being that responds. It is true, of course, that various conditioning agencies such as illness in relatives, newspaper articles, medical vagueness, etc., may cause a localization of complaints about a single organ or group of organs, but these are but outcroppings of the main difficulty and by them we must not be misled.

I am much averse to involvement in a hairsplitting classification of the psychoneuroses, since to me the fundamental mechanism at work is essentially the same in all. First of all there are the simple fatigue states regarding which there is no mystery and for which rest and reassurance are all that are required. Next there are the hysterical types, varying all the way from massive dissociation states in which the patient seems to have completely lost himself as in fugues, twilight states or convulsions, to the partial dissociation states in which segments or portions of the body only are involved. Such include the hysterical paralyses and contractions, the aphonias, the amauroses and other sensory disorders. It will be noted that in all of these the attempted resolution of conflict or appeasement of inward uneasiness takes the form of social appeal. The manifestations are appreciable to others directly. Inward distress is assuaged by, as it were, an appeal, albeit not a consciously elaborated appeal, to compassion, with whatever gains emanate from that —security mostly.

The third great group is those in which anxiety is the outstanding symptom. Hysteria, as Crichton-Miller points out, is a social type of reaction. Anxiety is essentially individual. In it the individual is faced with a dilemma in which desire and fear contend for the mastery. Coupled with this and consequent upon it is strong repression. The final picture is anxiety with all its visceral and vasomotor accompaniments, all in turn dependent upon unbalanced autonomic function.

The state may be a generalized one with rapid pulse, tremor, wet hands or the manifestations, being localized as has been noted, may constitute a picture of what has come to be called latterly psychosomatic disorder. And among these we recognize such semi-entities as effort syndrome, emotional hypertension, stress dyspepsia, duodenal ulcer, emotional diarrhoea, etc. Of these duodenal ulcer is presently rousing much interest and speculation. One has heard that a sizeable proportion of those already invalided home from the present war have duodenal ulcer and this in the face of better selection of men, and better dietary than held in the last war.

All that I have said is equally true for the psychoneuroses of those on service and those in civilian life. There is no distinctive war type. What the soldier, sailor or airman may display as the result of his special wartime experience he might quite as well develop under adequate stress in civil life. The civilian himself exposed to the harassments of wartime as well as the hazards of peace may develop them. Were it not so, much medical practice, both special and general, would simply disappear. We here, hundreds of miles from any present threat, are aware of underlying uneasinesses and tensions. The "distant roar and rumble of chaos and confusion" echoes disagreeably around us. How much more disturbing is it for those who stand close to it or in its midst. Brave and patient and persevering as they are, life must be different for them; the wearing down must be going on insidiously. One might suspect that with them it may well be as with the "nervous" individual who astounds his friends by standing up to a crisis magnificently, only to break when the actual crisis is past.

We have become accustomed to the term "war of nerves". We know what is meant, even though we may object to it as inaccurate. War has always carried with it an inevitable psychological tension but never before has this been so deliberately capitalized as a weapon. It is, as Bion says, a psycho-therapeutic procedure in reverse. The enemy for his own advantage utilizes for the first time knowledge of the springs of human attitudes and conduct. By what appears to be diabolical ingenuity, fears and wishful thinking are stimulated. The civilian lacks the psychological preparedness possessed by the trained soldier. The maintenance of morale calls for careful thought and the application of theories that appear to be based solidly enough. There, no doubt, are many avenues of appeal—songs, slogans, cartoons, etc., are some of them but their effect is, one would be inclined to believe, somewhat evanescent. The grouping of people into organizations with actions directed toward definite objectives does much to balance social sense and individual urges and isolation. Menninger states that *work*, *play* and *knowledge* are the best guarantors of civilian morale.

Those who recall medical work during the last war or who may have had occasion to review the medical writings of that period will remember the remarkable number of therapeutic procedures that were tried. Each one had its enthusiastic protagonists. Were a similar consensus of the present day available one ventures to think that there would continue to be found some support for each and most of these types of treatment. Anaesthesia, however, would probably be found to have given place to prolonged narcosis. Electricity would likely have dropped back to a lesser position, as might also have hypnotism. Otherwise I believe the list would be much as before. Psychoanalysis cannot be available for many civilian cases, let alone those occurring under the strenuous conditions of war.

Pharmacological treatment, limited largely to the judicious use of sedatives and hypnotics in the acute states, continues to have a place. The indiscriminate and thoughtless use of such substances can of course result in nothing but harm. The acute case occurring more frequently under the stress of war than under peacetime conditions has, as Wright points out, become to a greater or less degree the frightened child. For him the world is a terrifying place and his need is for all that the mother has given him in the past—security, food, warmth and rest. These are what must be supplied, but at all times the patient must understand that the ultimate objective is restitution to his former state of well being. Nothing must be done that will in any way lead to stabilization of the undesirable regressive neurotic reaction.

The chief dependence must be upon the group of procedures and techniques coming under the term psychotherapy. Many, and I should say a great many, know the word but what it means is a different matter. To them the word stands for a rather vague and ill defined concept including anything from a sort of flank attack on the patient's beliefs and complaints by sweet and reasonable reassurance, to the direct frontal attack of vigorous affirmation that the patient really has nothing wrong with him and should be ashamed to believe, let alone say, that he has. There are occasions when these special and rather simple techniques work but they frequently do not. In reality psychotherapy is a much more complicated procedure that must be thoughtfully utilized.

In attempting to help the psychoneurotic patient one is really embarking upon an educational process. The initial

fault in the patient's life may be close at hand, historically speaking, but it is much more likely to necessitate a laborious, difficult and at times discouraging effort to dislodge and overcome it. One may with a speed suggesting a miracle dispose of one manifestation, but lying behind this is a personality, full of trouble, deficient and in some respects crippled. That is the real problem. Firmly set beliefs and even rooted prejudices must be overcome. Relapses occur; in fact we may expect them and be prepared for them. Recovery is rarely a smooth uninterrupted rise. It is more often a series of advances and regressions, the latter rarely of the duration of the former and, when things go well, progressively more and more brief.

Some of these people come to us in really robust physical health. Many, however, because of their disturbing preoccupation with their viscera, their tampering with diet, their misdirected self-efforts to treat symptoms, their broken or generally inadequate rest, need wise guidance and sensible regulation of their lives. Some do not really want to part with their neurosis. It has come to be a shield against other things that seem less desirable and less comfortable. They may have gone long past any conscious recognition of their own motives. They may never have glimpsed them. Those who are utilizing their neurosis as a defence, a compensation, as a means of retreat to a semi-infantile dependent state, or are living out an expiation of a potent, even if dimly recognized sense of guilt, are the trying ones. They are being asked to give up something of real value and something of greater value must be supplied.

We all grant, even if we pretend to no particular prescience in the matter, that people vary in the degree in which they possess something variously designated as mental resistance, capacity for adjustment, integration or plain intestinal fortitude. Some having slipped into a psychoneurosis will with assistance speedily scramble out of it and this applies to civilians and soldiers alike. Others will not respond so well even though treatment is faultless, for the simple reason that their own contribution to a restored state is deficient. These are the people whom we should if possible keep out of the Services. Their prior detection is difficult but that it can be done in some degree is shown by the experience of the last war, in which the United States by a sifting and winnowing process kept their psychiatric casualties down to 9.5 per 1000 while such casualties numbered 24 per 1000 in the Canadian Army and 34 per 1000 in the British Army. Similar care in selection is reported by Mira as being responsible for the relatively small number of psychiatric casualties in the Spanish Republican Army.

I have said that what is most desired is the avoidance of the kind of state that pyramids upon itself. Unless treatment is speedy, efficient and constantly directed in both patient's and physician's minds by the ultimate aim of recovery and restitution, chronic invalidism results. This is particularly likely to occur where there is a question of compensation. It is an amazing fact that there are many people in the world who will sacrifice anything for monetary gain and this even if the supposed gain is grossly out of proportion to what is sacrificed. Psychoneuroses of either civilian or military life should not be looked upon as continuative and inexorably progressive maladies. They should be considered as more or less crippling interludes which with due recognition and proper treatment before the stage of stabilization can and should be cured. It should be impossible for any one so afflicted to look forward to thereby and therewith establishing for himself a life-long annuity. Com-

pensation, if it enters the picture at all, should have a limit in both amount and time.

The whole subject is immense, as broad as life itself. Its intricacies and complexities are a little more evident, a little better understood than they were twenty years ago. But of these important and fateful mechanisms, the source of an immense reservoir of human unhappiness and misery, there remains much to be disclosed. In them, there "gleams an untravelled world, whose margin fades forever and forever as we move."

Reaction to Publicity

How do we react to the virus of publicity? The answer to this question depends largely on the virulence of the infection and the susceptibility of the subject. Experts on publicity have invented a language of their own and scientific facts are presented in terms of news rather than propaganda, and emphasis is placed on personal contact and local colour. Successful distributors of publicity must be well versed in the subject to be publicized, in the tactics of camouflage, and other publicity techniques, and must be enthusiastic and consistently persistent. Success also presupposes thorough preparation of the ground before the seeds of publicity are sown. All this sounds fairly simple but really entails a good deal of hard work.

In the light of this preliminary statement we propose to offer the readers of the *Journal* a summary of the publicity programme undertaken by the Canadian Nurses Association, and to ask for comments on it. Its purposes were clearly set forth in the September 1942 issue of the *Journal* and read as follows:

> The stimulation of interest in nursing as a national service of a permanent nature, in order that a sufficient number of desirable applicants may be available in approved schools of nursing: (a) to keep up present enrolment; (b) for some increase over present numbers.
>
> To make known the need for specially qualified nurses to fill positions of responsibility, and the necessity for post-graduate courses.
>
> To interpret nursing to the public (a) as an essential community service; (b) as a special opportunity for national service, and as a career; (c) in its many implications and expanding fields; (d) as a profession that has accepted many responsibilities in meeting public needs.
>
> To interpret nursing education as a preparation for life and service.
>
> To stress the responsibility of the public towards nursing service and nursing education for the purpose of obtaining interest, moral support and financial aid.
>
> To recognize the value of the subsidiary and voluntary worker, and to define and evaluate her functions as related to those of the graduate nurse.

Study of these objectives definitely suggests that the publicity undertaken by the Canadian Nurses Association must be designed to reach members of the nursing profession as well as lay groups, and also that it should be prepared with a view to awakening interest among people of all classes.

The publicity programme sponsored by the Canadian Nurses Association

under expert guidance, has been underway for a period of six months. What are the results? After generations of professional reticence, nurses have gradually become aware of the importance of sharing their professional problems and achievements with others. They accept the fact that, in order to secure support and assistance, it is essential to be understood. In such a "right-about-face" policy the results must of necessity be slow. The measuring rod for any publicity scheme must be a long one. Results are somewhat intangible and we must ask ourselves — what would the situation have been without it? This question is not easily answered, so at this time about all we can do is to make a statement on the form that the national publicity programme has taken.

Since July 1942, several important developments have been initiated. A memorandum has been sent to the editors of all newspapers in Canada, some 211 in number, outlining the problems of the nursing profession and asking for sympathetic consideration and treatment; this memorandum took the form of a personal letter from the President of the Canadian Nurses Association. Four newspaper releases have been sent out to the Canadian Press and these releases have resulted in 68229 lines of reported *free* publicity, plus many more lines that were not reported. The number of words in these lines would fill eight magazines of the same size as the current issue of the *Journal*. Copies of a speaker's hand-book, providing pertinent information and sample speeches that should be helpful in carrying on local publicity programmes, have been forwarded to each Provincial Association of Registered Nurses. A memorandum, outlining appropriate organization for a "Nurses' Week", has also been sent to each province. In August, Miss Margaret Lawrence kindly published an editorial in the "Canadian Home Journal" and, in October, the rotogravure section of the "Montreal Standard" devoted several pages to a beautifully illustrated article on nursing. In the February issue of "Chatelaine", nursing is to be featured in a special way .Unfortunately, the date of the publication of these articles cannot always be announced very far in advance and it is possible that some members of the nursing profession may have missed seeing them. These magazines have a very wide national circulation and reach many people in all parts of Canada; they are evidence of support that is very valuable and for which the nursing profession is grateful.

Miss Jean E. Browne, National Director of Junior Red Cross, is also arranging for an article on nursing to appear in the Junior Red Cross Magazine. It is realized that this message will go to thousands of students across Canada.

Already the Canadian Broadcasting Corporation has very generously given radio time for two coast-to-coast broadcasts on nursing and, according to present plans, another message from the Canadian Nurses Association will soon have been heard across Canada. Thanks to the kind co-operation of the Department of Pensions and National Health, a series of references to nursing are being given over the various networks of the Canadian Broadcasting Corporation; these began in October and are now being heard several mornings a week from C.B.C. stations. Listen for them just before 8 a.m. E.S.T. No doubt some of our readers saw the "flick" that presented "Soldiers in White", a brief but effective story of nursing that appeared as a newsreel item in all motion picture houses throughout the Dominion.

So much for our national achievements in 1942. Early in the New Year,

we hope to release an illustrated folder for the information of high school students and others who are interested in nursing. This has been prepared to give a general picture of nursing and, while it can never take the place of personal appeals and talks, it may well be supplemented by giving additional information of a more detailed and local nature. Special letters on distinctive stationery are also to be made available for use through Provincial Associations. One of these letters is prepared as a direct appeal to university graduates and students. Another is intended to approach suitable young women who belong to various church groups and may be interested in nursing. As a further aid to publicity in the provinces, enlarged photographs descriptive of nursing and a striking poster have been prepared as part of the national publicity programme. These may be used in exhibits and window displays, and as special features in high schools or at lay conventions.

Beginning early in the year, weekly radio bulletins, dealing with some phase of nursing, are to be sent out to some sixteen private radio stations across Canada. As these are to be prepared by an expert they will be sufficiently interesting to ensure a wide and attentive audience.

Effective publicity is expensive if approached on terms of dollars and cents; in any event, it demands time and specially directed effort. Money has been spent on some of the items referred to in this article, but the most valuable have been given free of charge in recognition of nursing as an indispensable service. As a profession we are grateful for this recognition. We are also most deeply grateful to those who have contributed to publicity projects as part of their war effort. Busy hospital administrators and department heads, as well as those who have lent themselves as "subjects", deserve honourable mention. They have been most generous in giving the assistance which was so essential. Only those who have followed in his wake — trembling at times — realize just what havoc one genial photographer (in blissful ignorance and unbounded enthusiasm) can create in a ward or department. And yet it is just this enthusiasm that spells success. After weary hours of posing, the "subjects" must sometimes have wished that they had missed the keen eye of the expert as it cast about for "photogenic" nurses. But whatever their personal reactions may have been, authorities in hospitals and health organizations have given their support graciously and generously. After achieving so much success, we hope that none of the "subjects" will be lured from the profession to plunge into a Hollywood career!

In acknowledging contributions to the publicity programme, we also have in mind the space so generously given in the *Journal* and the assistance given by the editor in dressing up articles arriving out of snow-drifts and prepared en route under conditions of travel that are not conducive to clarified thinking or legible writing. We are also grateful for the assistance, given behind the scenes, which has influenced the preparation of pamphlets, pictures, and other material.

And now we turn to the programme for the future. Publicity must be continuous if it is to be effective and, as it seems likely that direction by a national expert will be reduced, more responsibility will be placed upon the Provinces. Already much highly successful local publicity has been the result of direct effort on the part of the Provincial Associations and their representatives. Any national campaign must have local colour and interpretation if it is to secure local support. Consult the editors in

your own districts and they will tell you so.

There is no shortage of news today and free newspaper space is a gift of real value. Statements regarding accepted facts or policies are not news. For years nurses have worked unduly long hours, and they have served under all conditions and circumstances. In the mind of the public the nursing profession has always lived up to this ideal, and it is taken for granted that we shall continue to do so. To bring these and other truisms to the attention of the people, they must be presented in the form of news with local colour. You may suggest that the nursing profession does not lend itself to sensational development and that therefore it may be difficult to get headlines in the press. This is probably true, although an alert dissemination of news can find fruitful fields even within the protection of the profession. We even think that an astute reporter might have made "news" out of the fact that the first vice-president and the Emergency Nursing Adviser of the Canadian Nurses Association were found dozing in Peacock Alley at the Chateau Laurier, at 5.30 in the morning on New Year's Eve. Even though well chaperoned, we are definitely informed that they were up all night. In any event, we advise a periodic visit to your local editor in order to gain and hold their interest and secure their support. Reporters are also valuable friends although we advise against asking them what they think of nurses as co-operators in the newspaper world, unless you are prepared to learn much that, while not satisfying to your professional ego, may be useful to the cause of ensuring publicity concerning nursing.

KATHLEEN W. ELLIS
Emergency Nursing Adviser
Canadian Nurses Association.

New Year's Honours

The names of ten members of the Nursing Service of the Royal Canadian Army Medical Corps appear in the list of Honours awarded by His Majesty to the Canadian Army Overseas. The Royal Red Cross (First Class) has been awarded to Lt.-Col. (Matron-in-Chief) Agnes Campbell Neill, R.C.A.M.C.; Major (Principal Matron) Blanche Gertrude Herman, R.C.A.M.C.; Lieut. (Nursing Sister) Mary Winnifred MacNutt, R.C.A.M.C. The Royal Red Cross (Second Class) has been warded to Lieut. (Nursing Sister) Mary Lucy Clark, R.C.A.M.C.; Lieut. (Nursing Sister) Ida Henderson, R.C.A.M.C.; Lieut. (Nursing Sister) Elva Cynthia Mary Honey, R.C.A.M.C.; Lieut. (Nursing Sister) Doris Lillian Kent, R.C.A.M.C.; Lieut. (Nursing Sister) Edith Kergin, R.C.A.M.C.; Lieut. (Nursing Sister) Jean Sophie Taylor, R.C.A.M.C.; Lieut. (Nursing Sister) Jean Sherwood Taylor, R.C.A.M.C. Two members of the Nursing Service of the Royal Canadian Air Force have also been awarded the Royal Red Cross (Second Class). They are Nursing Sister Frances Marion Oakes; Nursing Sister Ruby Perella McSorley.

This well deserved recognition is a source of pride and satisfaction to us all. Hearty congratulations to the Canadian Nursing Sisters who, like our fighting men, are upholding the honour and dignity of our Dominion.

An Operating Room Set-up for Plastic Surgery

LIEUT. (NURSING SISTER) ALFREDA F. DEARDEN, R.C.A.M.C.

The Canadian Plastic Surgery Team, R.C.A.M.C., organized a year ago and attached to Park Prewett Hospital, has been very fortunate in being associated with an active Emergency Medical Service plastic centre. Exchange of ideas and adaptation of new methods has made the work doubly interesting. A theatre has been set aside for the use of the Canadian staff exclusively. This staff consists of a surgeon, an anaesthetist, two sisters and an orderly (part-time). The set-up and technique for cases is the same as on the British side and has proved most satisfactory.

The theatre set-up is as follows: gowns, gloves and glove towels are placed on a sterile table, set aside for that purpose. Three trolleys are used in the majority of cases; the first has the solutions for skin preparation, and the drapes; the second holds the instruments; and the third is for sutures, wipes and extras. Spirit is used for skin preparation and merthiolate 1 - 1000 for eyes and the mucous membrane of the nose and mouth.

The head drape is used a great deal. A sterile piece of jacconet, thirty by thirty-six inches, and two sterile sheets of the same size are placed under the patient's head. The two distal corners of the top sheet are picked up, crossed over the patient's forehead, and fastened in position with towel clips. The whole length of the patient is draped with sterile sheets, the chest drape is brought up to meet the head drape and fastened with clips, leaving only the operative area exposed.

After skin preparation and draping are done, the first trolley is practically discarded except for receiving contaminated instruments. The blunt instruments are boiled for twenty minutes, and the sharp instruments are placed in pure lysol for an hour before use. They are carried to the theatre from the sterilizing room in sterile covered containers; the sharp instruments are well rinsed in saline and dried before placing them on the table.

Black silk and fine wire sutures are used exclusively for the skin. A fine catgut on an eyeless needle is used whenever a subcutaneous suture or ligature is required. The silk and wire sutures are ready for use on needles and are threaded through a length of lint seven by five inches. These are called "suture sheets" and are sterilized by boiling with the instruments. Before placing them in the container, all water is squeezed out with sterile forceps and the sheet is dipped in spirit to prevent rusting of needles.

Apart from facial scars, reconstruction of noses, and the treatment of fracture of a malar, maxilla and mandible, there has also been a large number of skin grafts. The Thiersch is the most frequently used free graft. This graft may be taken with a Blair knife or Padgett's dermatome. The dermatome is the instrument used to remove the skin when a large graft, of even thickness, is required. The skin is usually taken from the thigh. The dermatome drum is painted with dermatome cement, and also the donor area. After skin has been taken, it is removed from the drum and placed on a board covered with tulle gras; this oily surface prevents the skin from sticking and the edges from curling. A warm saline sponge covers the board and graft until the surgeon is ready to use it.

The donor area is promptly treated with sulphonamide powder, tulle gras and saline dressings, before beginning work on parts to be grated, thereby lessening danger of infection from the area of operation. The final dressing is in all cases the same:
(1) sulphonamide powder; (2) tulle gras; (3) saline dressings.

We strive to maintain the highest technique insofar as we can in these difficult times and it is gratifying to note how few post-operative infections have occurred.

Editor's Note: The authority under which this article has been officially released for publication is indicated on page 96, under the caption of Reader's Guide.

The Nursing Care of Burns

LIEUT. (NURSING SISTER) D. A. MACHAM, R.C.A.M.C.

Burns form a fair percentage of the cases which come to the Plastic Surgery Team for treatment. We receive them at various stages of their clinical course. The cases we find most interesting are the ones we receive within a few hours of injury. Shock provides the first problem in treatment in the early burn. Warmth is very necessary and, if the patient has not had a sedative previously, one should be administered on admission. Usually this is morphine. The majority of these patients require very little sedative after admission, except a mild one, and that at bed-time. The temperature, pulse, and respirations are checked. If abnormal, they are taken every four hours; otherwise, twice daily is all that is necessary. When the face is involved, the temperature is taken by rectum, or by axilla, preferably the former.

A blood tray is prepared when the patient is admitted. This contains a ten cc. syringe, intravenous needle, and sterile sponges. Alcohol, tourniquet, and a tube with oxalate are also provided. The medical officer (and occasionally the Sister) takes blood from the patient for investigation. The blood is sent to the laboratory for red cell count, white cell count, haemoglobin estimation, plasma protein value, etc. Whether the patient gets whole blood, plasma, concentrated serum, glucose in saline, or nothing intravenously is decided by the result of this blood investigation. While any form of intravenous therapy is being given, the patient must be watched for a reaction. This takes the form of chills, usually fever, and occasionally vomiting. The intravenous is discontinued if the medical officer is not available.

A dressing tray is prepared. On this, there are three dressing forceps; one McIndoe forcep, which is a fine pointed tissue forcep; a sharp pointed pair of scissors; basins with soap solution, saline, tulle gras, sponges, dressings, and culture tubes. Sulphonamide powder, bandages, adhesive, and safety pins are on the dressing carriage.

Masks are worn by the nursing sister and the medical officer while the dressing is done; this also applies to all subsequent dressings. One dressing forcep is used to remove the emergency dressings; this is not done until the surgeon is prepared to do the primary hospital treatment. At this time, he washes the burned area, and surrounding area,

gently, with soap and water. All dead skin is cut away, using the fine scissors and the McIndoe forceps. Swabs are taken for culture. A light sprinkling of sulphonamide powder is dusted over the burn, tulle gras is applied (one layer only) and warm saline compresses over this. The compresses are then covered with dry gauze, absorbent cotton, and bandaged.

When possible, photographs are taken at the time of the first dressing for record purposes, before any surgery is done. Photographs are also taken before any operation is done, and before discharge. It is the responsibility of the Sister to see that these pictures are taken.

As mentioned above, a swab for culture is taken at the first dressing. Usually one, or more, is taken every second day for the first ten days, then at intervals, as ordered. This indicates if cross infection has occurred, and also any change in the type of organism present. Change in the type of organism present may mean a change in the nature of the dressing; that is, eusol in place of sulphonamide and saline. Tannic acid is sometimes used on burned areas that are clean; it is not used on the hands or face. When tannic acid is used, the Sister must watch, and report, any softened areas in the tan. Daily, she paints the edges of the tan with an antiseptic coagulant such as gentian violet, one per cent. As the edges of the tan loosen from the skin, they are trimmed with sharp scissors.

Sulphonamide is shaken from a can with a perforated top, or blown on the burn from an insufflator. When the drug is being used on extensive burns, a specimen of urine is sent to the laboratory daily to be examined for red blood cells. If such cells are found, the sulphonamide dressings are discontinued. Blood is taken every second day for estimation of the blood level of sulphonamide. In cases where large areas are burned, it has been found that sulphonamide can be absorbed in sufficient quantities to cause toxic symptoms. The Sister should watch the lips, finger-tips, and toe-nails for cyanosis, which is one of the signs of toxic absorption. Delirium is also a symptom of such absorption.

Tulle gras is made from a net curtain material of 2mm. mesh, cut in required sizes, and placed in covered tin boxes. Over the net is added a mixture of vaseline (98%) methylated spirits (1%) and tr. benzoin co. (1%). This preparation is spread thickly over the top layer (thickness depending on the number of layers of net). The boxes are then covered, sealed with adhesive tape, and autoclaved at twenty pounds pressure for twenty minutes. When properly prepared, the threads of the netting should be well soaked in the vaseline mixture, but the perforations should be quite free. It is necessary to change the tulle gras once daily. The outer dressings may be removed and the saline compresses moistened, using a saline filled syringe, twice daily, or oftener, if the patient complains of the dryness of the dressing. This is less trying for the patient and saves gauze.

Saline baths are found to be of great aid in the cleansing and healing of burns. The bath is partially filled with normal saline at body temperature. The patient is placed in the bath with the inner dressings on. While the patient is in the bath, one gallon of warm saline is added automatically every minute. The dressings float off as the patient moves about in the bath, which he is encouraged to do. Patients who have burns of the buttocks, and, consequently, find it painful to use a bed-pan in bed, may be given an enema at the end of the time in the bath. Those patients who have burns of the fore-arms, or hands, or both, have an hour daily in a

hand bath. When persistent streptococci are present, soap baths are substituted for the saline hand bath.

Fluids by mouth are pushed. In all serious burns, a chart of the intake and output is kept. Laxatives, or enemata, are quite necessary. The lips must be kept well oiled with liquid paraffin, or vaseline, in all burns of the face. In burns of the eye region, careful irrigation with boracic solution is done at each dressing. Close watch must be kept of the sacral region, and pressure sores guarded against.

Skin grafts are used in those patients who have had third and fourth degree burns to speed healing. After healing has occurred, whether by grafting or naturally, careful daily massage is done with lanolin. In those cases which have healed naturally, care must be taken not to injure the new covering, as the lightest touch may produce a blister. In those patients with burned hands, protection after healing may be provided by cotton mitts with a draw string at the wrist. These afford protection from the weather. This obviates the necessity of bandaging the hands. Large burn dressings take a great deal of time, are tiring, and cause the patient pain and discomfort. The number of nursing hours required for burn patients is greatly in excess of that required for a similar number of general surgical patients.

This is an attempt to outline the nursing care of a burn patient admitted to our unit. Careful and thorough nursing is an absolute essential in the treatment of all those seriously burned and the Sister responsible for these cases becomes very interested in the work. This probably is due to the fact that in the majority of cases, the almost daily improvement is adequate return for the time and care expended.

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R.C.A.M.C. Nursing Service

Official announcement has been made of the safe arrival in Britain of 85 members of the R.C.A.M.C. Nursing Service. Most of the Nursing Sisters came from the London-Kitchener area of Ontario and Principal Matron E. R. Dick was in charge. Many units of the Canadian Army were represented in the reinforcements who sailed at the same time as the nursing group. The voyage across the Atlantic was rough, but everyone landed in good spirits and ready for the task which lies ahead.

The Nurse Has Wings

So successful has the co-operation been in North Africa between front line American Army nurses and air-borne troops, that the American Army authorities are now forming a new branch of the Service—an aerial nurse corps. These "para-nurses" will land at the scene of battle just when they are needed, bringing expert treatment to the wounded soldier—in time. Entry to the Air Service is by strict selection test: every applicant must be both a registered nurse and physically fit. Commando training, under austerity conditions, is of the standard applied to the male paratroop. Physical fitness perfected, the potential para-nurse gains knowledge of her parachute, practises jumping and finally takes the air. Training includes nursing in the air and experience in landing at air bases.

—*Nursing Times*

Contributed by the Hospital and School of Nursing Section of the C. N. A.

Nursing Care of Myasthenia Gravis

B. DEXTER *and* C. KWONG

Myasthenia gravis is a chronic disease of unknown etiology, chiefly affecting young adults. The most significant symptom is great muscular fatigue which is quickly brought on by repeated movements and tends to disappear after rest. The ocular muscles are affected, and diplopia is a common early symptom. The facies is characterized by a sad, sleepy, mask-like expression with ptosis of the eyelids, which may be either unilateral or bilateral. Sudden attacks of dyspnoea or dysphagia frequently occur which sometimes prove fatal. The muscles do not atrophy, except from disuse.

It is a known fact that a nerve impulse is transmitted to the muscles through the mediation of a chemical substance which is produced at nerve endings. In the parasympathetic nerve, the chemical substance is acetylcholine and, in the sympathetic nerve, it is epinephrine. Both of these chemical substances are quickly destroyed by enzymes at the myoneural junction, so that their period of activity is very short. Such drugs, therefore, as ephedrine, prostigmine, quinidine hydrochloride, and potassium chloride, have proven beneficial to patients with myasthenia gravis, since they inhibit the destruction of acetylcholine and epinephrine, thus giving them a longer period of activity.

It is believed also, that the thymic gland is associated with myasthenia gravis. In 1901, a thymic tumour was found at necropsy in a patient suffering from this disease. Since then, many other thymic abnormalities have been found present in such cases. The first operation was in 1936, when an anterior mediastinal tumour was removed from a patient who remained well, except for one insignificant relapse, ten months after operation. A few other similar operations have been performed, and the thymic gland in each case was found either to be enlarged or to contain a malignant tumour. The results thus far have been successful and the remissions fairly complete, although recurrences have been reported. Roentgen irradiation of the thymus region has proven highly beneficial. Remissions, following this type of therapy, have been accumulated to a degree sufficient to lend weight to the hypothesis of the thymic origin of myasthenia gravis.

Because the most significant symptom is fatigue, the nursing care of patients suffering from myasthenia gravis is rest. The environment is very important. The patient should be placed in a gatch bed with a firm mattress and light but warm bed clothing; the room should be well

aired but no drafts; and the bed should be placed out of direct sunlight, since ultra-violet light is contra-indicated. If the patient is dyspnoeic, he should be put in Fowler's position, otherwise he may rest in the position which is most comfortable. Exposure to persons with colds or other chest conditions should be carefully avoided. Because of dyspnoeic and dysphagic attacks, the patient is often apprehensive, so should be spared any anxiety, since anxiety also causes fatigue. Reading material should be carefully selected, the lighting in the room controlled, and the table within easy reach. The nurse can do a great deal to prevent any unnecessary fatigue to the patient by anticipating his needs, keeping noise down to a minimum, restricting visitors and by helping him to solve any home and financial worries.

In severe cases, the patient is placed on complete bed rest. A daily bath, with water at body temperature, followed by a gentle oil massage, keeps the skin soft and healthy as well as aiding muscle tone. Special care should be given to the scalp, mouth and teeth. The bedclothing should be kept fresh and free from wrinkles to prevent the patient from becoming restless. Exercise should be regulated according to the condition of the patient, and he should have a short period of rest before and after meals in order to conserve strength for eating. These patients should be fed, as the mere chewing of food exhausts them, and the feeding should be slow and in small amounts. The diet should consist of soft or semi-solid foods to prevent the necessity for much chewing and there should be a rest between each mouthful. The masseter muscles tire very easily. If the food is given in small amounts, it will help to prevent choking or regurgitation, both of which are tiring. In severe cases, nasal feedings are indicated. Fluids should be given liberally to prevent dehydration, and should include glucose drinks, milk, and eggnogs.

Other treatments given in this disease are a small Mayo enema for constipation, a rectal tube for gas or distention, and oxygen therapy for dyspnoeic attacks. The medications at present being used are ephedrine sulphate, which should not be given too near bedtime, since it causes insomnia; prostigimine, which is started early in the morning and continued until late at night; quinidine hydrochloride and potassium chloride, all of which inhibit the destruction of acetylcholine and epinephrine. Mild aperients are given to keep the bowels regular and barbiturates for sleeplessness.

The patient must be closely observed for any complications such as dyspnoea or dysphagia, and symptoms of worry, over-anxiety and nervousness. The intake and output should be carefully checked and exercise regulated. The patient should also be carefully watched for toxic symptoms from the medications, which are nausea, vomiting, abdominal cramps, blurred vision and insomnia. The course of this disease is very irregular—it may last from a few months to years. A definite cure has not yet been found, the only hope at present being in remissions. Death usually occurs from such complications as bronchopneumonia, choking or respiratory failure.

Health teaching is of the utmost importance in myasthenia gravis. The patient should be instructed to avoid getting chilled and to reduce activity in hot weather. He should have any foci of infection removed and particularly avoid colds and chest conditions. A low-gear life is indicated with plenty of rest and sleep. Eating habits should be regular, preferably small frequent feedings of nourishing foods. Regular habits of elimination are also desirable. The im-

portant factor is rest, rest and more rest, remembering that over-exhaustion of one group of muscles can tire other groups of muscles. If the patient should contract a cold or is menstruating, she should stay in bed until fully recovered. Recurrence can follow remissions.

Further studies now in progress are necessary to evaluate correctly the role that Roentgen irradiation and complete surgical removal of the thymus are to play in the treatment of myasthenia gravis. Meanwhile we can be grateful for effective symptomatic treatment with prostigmine, ephedrine, quinidine and potassium salts.

Practice for a Blitz

M. Helen MacKay

Today, when bombers span half the world with their loads, no community is safe from the danger of an air raid. Doubtless all citizens wonder at times how effective their own precautions and organizations would prove in such an event. Hospital staffs have the added problems of efficient organization and administration for the adequate care of a large influx of patients with many types of injuries. We, in our hospital of 130 beds, in a small city of approximately 7,000 people, shared these apprehensions. Unexpectedly we had an opportunity to test our abilities, though fortunately not in an air raid. We heard that a railway wreck had occurred about a hundred miles away and that five or six people were injured and would be brought in to the hospital later that night. A special train was sent out to get them and two doctors and three registered nurses from the town went with it; we prepared an emergency suturing set, extra dressings, bandages, stimulants, anti-tetanus serum, intravenous equipment, tannic acid and sulphadiazine to send along.

The operating room staff sterilized the blood transfusion set, amputation saws and emergency instruments in preparation. The staff of the surgical floor left extra dressing and intravenous sets, tannic acid and sterile supplies for our night staff of three graduates and six students. Then we went off duty, confident that the night nurses could manage with possibly, the assistance of the operating room nurses. The special train was not expected back till the early hours of the morning but at 12.30 a.m. the six day supervisors were aroused with the news that forty-five patients were coming in on the train at 1.50 a.m. Nine nurses could not be expected to prepare for and cope with that many patients so we dressed hastily and went over to the hospital. Many of the senior students were called on duty and others were aroused by the unusual sounds and came over of their own volition. Those who slept peacefully through it were quite disappointed to find they had missed the event. We were glad to have some of them fresh for the hard day's work ahead.

An understanding of the hospital structure might be helpful at this point. It is a three-storey building; the first floor is administrative with a small ma-

ternity department in one wing; the second floor, accommodating approximately 60 patients, is medical; the third floor is surgical, accommodating about 50 patients, with the operating rooms adjoining it. A small isolation hospital, staffed when necessary by our nurses, stands on the hospital grounds. One end of this was unoccupied and ten beds were made up there to be used for less critically ill patients.

The superintendent of nurses had telephoned a doctor from each clinic in town asking them to come and discharge all patients who could safely go out, as we only had twelve empty beds for the forty-five patients. This was facilitated by a system we inaugurated soon after the war with Japan broke out. Beds of patients who were not seriously ill were kept marked with green cards, those of patients who could go if absolutely necessary with blue cards, and those of patients who were unable to go with red cards.

Meanwhile extra stores of linen were hastily heaped in wheel chairs and taken to the floors where they were sorted into piles for easy distribution. The nurses and the orderly were bringing out beds, opening them up, placing hot water bottles in them, and a pneumonia jacket, nightgown, towels and facecloth on each one. Tags were tied to the head of each bed and when the patient came in his name and religion were written on each tag. Students were obtaining clothes and assisting discharged patients in their preparations for leaving, then stripping and remaking the beds with fresh linen.

By this time the secretary-manager and the chairman of the hospital board had arrived. The latter brought his daughter, a student nurse from the Vancouver General Hospital, and she and one of the supervisors took linen and extra supplies and prepared the isolation hospital for use. Our dietitian came over and made hot coffee. The laboratory technician was called to be on hand for the inevitable laboratory work. After the beds were ready, extra equipment was prepared, such as instruments, needles, intravenous sets, etc. The operating room staff autoclaved an extra amount of solutions and sterile supplies. Then the medical and surgical supervisors made a survey of the available male and female beds on each floor, as well as those beds which could be used for either. Copies of these lists were sent to the superintendent.

At 1.30 a.m. we were ready and enjoying our coffee while we discussed arrangements for admitting patients efficiently. It was decided that the superintendent, and one of the supervisors with their lists, would be at the ambulance entrance to direct the distribution of the patients. The more seriously injured would be taken to the surgical floor and the less seriously injured and ambulatory patients would go to the medical floor and isolation hospital. Fortunately we did not have to use the latter.

Three supervisors and the students, with one of the doctors who brought the patients in, waited at the elevator on the surgical floor. As each patient was brought up, the doctor indicated the type of accommodation desirable and a supervisor and a student accompanied the stretcher to the bed. They assisted in lifting the patient into bed and the student remained to perform any necessary tasks. Clothing was piled on the floor under the bed till later and the supervisor returned to the elevator for another patient. A similar arrangement was carried out on the medical floor. Another supervisor and the secretary-manager admitted ambulatory patients at the main entrance and formed some idea of the extent of their injuries. Chairs were placed in readiness in the hall and

couches in the waiting room. Later, the doctors came down and admitted those requiring hospitalization or allowed them to go to hotels after caring for superficial injuries.

As this is a railroad city the news had spread and, as we watched the procession roll up to the ambulance entrance, it seemed as if every delivery truck in the city must be helping. Provincial police directed the traffic and ambulances and trucks were swiftly unloaded and the stretcher cases quickly taken up on the elevator and slipped into clean warm beds. A total of thirty-five patients were admitted. The doctors then began their rounds, aided by lists of patients and the numbers of their rooms; one of the supervisors had listed them while the others were admitting the patients. There were several bad burn cases due to escaping steam. These had been sprayed with an aqueous sulphadiazine solution at the scene of the wreck, then with 5% tannic acid in the hospital. Later, when the coating began to peel, sulphadiazine ointment was applied. The results of this treatment were very satisfactory. Sulphathiazole powder was used in all wounds treated in the operating room, also with good results. Suturing and transfusions kept the operating room staff and some of the doctors busy till well into the morning.

By 5.30 a.m. we were able to turn our attention to minor details, such as listing clothes and making out charts. At 6 a.m. we were calling special nurses and married graduates, from lists previously compiled for the Red Cross Emergency Committee. This list included many who had not nursed for some time and they were a bit dubious, but when told of our need quickly agreed to come and do what they could. They did very well and seemed thoroughly to enjoy it. Our students, who had been up practically all night, were thus enabled to go off duty and get a few hours rest. Donors were called for over the radio that morning and many came up for typing. These were summoned as needed during the days which followed. Now, should the occasion arise, we feel that this experience would stand us in good stead.

The Almonte Disaster

Late on the evening of December 27, word was received at the Ottawa Civic Hospital that a bad train wreck at the nearby town of Almonte had resulted in many casualties, some of whom were to be sent to us. A very few of the graduate and pupil day staff were notified about 2.00 a.m. and reported for duty to assist in the necessary preparations. Extra supplies were autoclaved, emergency equipment was made ready for use, and a census of the empty beds in the hospital was taken to ascertain where the expected patients might be placed most advantageously. The exodus of patients for Christmas accounted for the available accommodation. Beds were turned down, extra rubber sheets and hot water bottles were placed in them, and all was made ready.

A special hospital train had been despatched from Ottawa to bring back the victims, and the first report told of its expected arrival at 3.30 a.m., then

at 4.30, and then at 5.30 a.m. Stretchers were lined up in the corridor outside the ambulance entrance waiting . . . then the first ambulance turned into the drive! In the admitting department there were six or seven of us, two or three orderlies, the others nurses, and a man to open the doors and to keep the ambulances moving as quickly as possible. Two stretchers were placed ready on either side of the entrance door. The ambulance stopped, and out came a stretcher bearing a desperately injured girl. The ambulance men held the stretcher up level with our wheeled stretcher and quickly, gently, many hands helping, she was lifted to one of the waiting stretchers, the ambulance blankets and hot water bottle removed, covered with our blanket and hurried into the warmth, where a doctor and nurse obtained the necessary data and assigned her to a ward to which she was rapidly taken. Several patients bore tags suggesting immediate x-ray or surgery.

Meanwhile the first ambulance had driven off for another patient and to make room for a second and a third. One after another, at about two-minute intervals, the injured were lifted to our stretchers and taken in as quickly as hands and feet could work. A camp cot, a door, stretchers of every kind and description, followed in a steady stream. Blankets, quilts, hot water bottles of all sizes and colours, glass bottles filled with hot water and wrapped in newspapers—all were used to lend warmth to the patients. Within about an hour and a half between sixty-five and seventy stretcher cases had either been put to bed or were well on their way there, and three or four wheel chair patients had been cared for. Throughout the day, shock was treated with plasma, fluids and heat, fractures were reduced, wounds were cleaned up and dressed, and quiet and rest were established.

The first aid carried out on these poor people before their arrival was well worth comment and we saw what could be done with boards, magazines, papers, pillows, stockings, scarves, and belts. Everywhere we heard comments on the excellence of the first aid treatment given. Undoubtedly, this fine work contributed greatly to the alleviation of shock. One vivid impression of these casualties will remain with me always—the hue of those persons badly shocked. We have seen the pallor of shock before but the ashen greyness of those people was something not easily forgotten.

We have had a taste of what can, but we hope never may happen in Canada — a blitz! The nurses who returned with the hospital train certainly looked as though they had seen tragedy and human need as never before.

—E. Gertrude Ferguson

A Correction

Editor's Note: A most unfortunate typographical error appears on page 34 of the January issue of *The Canadian Nurse*. In a synopsis of the cases of burns treated at the Montreal General Hospital with the pressure emulsion technique it was erroneously stated that "22 deaths occurred both within two to three hours." Obviously the number of deaths was *two*, and not twenty-two. We deeply regret that this mistake escaped the usually vigilant eye of the proof readers.

Community Health Experience

CLARA E. JACKSON

In the nursing field we are constantly re-adjusting our educational program to meet the needs of the public demand. We have been told we were educating nurses to nurse within the confines of the hospital walls, that we had graduated nurses whose knowledge of home nursing was nil. Many found themselves unable to transfer their learning to the home situation and had difficulty in working amongst all sorts and conditions of people. Realizing our mistake, we set about to provide a remedy in the hope that future graduates would make an easy adjustment in any home situation and have some knowledge of the contribution other groups make to the public welfare.

Many outside contacts are made by student nurses in the School of Nursing of the Brantford General Hospital, an institution which has 250 beds. Many of you will have made similar contacts and we don't feel ours are perfect by a long way but we are satisfied that we are making progress in the right direction. We have the full co-operation of our civic departments, and industrial and public health organizations, as well as those of outlying districts to a distance of 65 miles.

The student makes her first outside contact at the pasteurization plant. Arriving at the same time as the farmer with his milk, she is encouraged to chat with him and to learn first-hand about his problems. She then observes the company officials test the milk for odour and cleanliness, weigh it and remove a sample for butter fat test and for bacteriological count. She sees the process of pasteurization from start to finish, observes the capping, spraying, and storage processes, and finally samples the finished product.

Her next contact is at the city water works where the city engineer tells her the story of the water travelling from the river to the consumer's tap. She watches the various processes of filtration, sedimentation, chlorination, and testing. She is told of water storage and usage and observes the cleansing of the sand beds used for filtration. A second engineer demonstrates the generating of electricity to meet city emergencies, such as interruption or failure of the hydro supply due to storms and other causes; also for reduction of the peak load (the maximum demand), thereby lessening the load upon the main hydro system and incidentally saving expense.

Now for a day in Toronto, where the morning is spent at the School of Hygiene at the University. Here the student sees moving pictures of the development of the School and the experimental farm, receives instruction and observes demonstration in immunization products and glandular preparations for glandular therapy. The afternoon is spent at the public health department research laboratories in the Parliament Buildings. With a doctor as guide and instructor she is taken through various research laboratories where work is being carried on in venereal diseases, tuberculosis, pneumonia, streptococcus, and staphylococcus, typhoid fever, parasites and others. Then she goes up to the laboratories where animals and birds are used for experimental purposes. She sees animals removed from cages and examined, negative and positive tuberculin tests are demonstrated and there is a discussion as to the meaning and

value of this work. Now she is introduced to the research department of industrial hygiene where various phases of industrial hazards are being studied. These are explained briefly and then she is escorted into a dark room where she observes under violet rays the testing of bed and pillow fillings, some all new, some all old, some mixed, a process which enables the health department to detect and prosecute anyone using old material and selling for new, and so protects the public and supports public health measures. A demonstration of the respirator used in industrial work completes her day.

Now we turn to the social service worker with whom she spends three mornings, and who has a definite program arranged as follows:

A home investigation visit which may have to do with illness, poverty, unemployment, marital difficulties, or problems arising in cases of unmarried mothers.

A birth registration call for the purpose of instructing the mother in the routine care of the baby (especially the first birth).

A call on older babies to see that instructions are followed, and to advise as to dietary changes.

A call in pre-school children.

A pre-natal call.

The feeding of the family, which is of vital importance in the promotion of health, comes into the discussion in practically every home.

In her second year the student has three weeks in the community divided as follows:

Three half days with the school nurse and doctor, observing the testing of eyes, and school room inspection for rashes and pediculi. She also helps to prepare the children for a general physical examination, and studies the records.

Six afternoons with the social service worker attending the well baby clinic. Here she weighs the babies and observes the work of the department.

The rest of the time she spends with the public health nurse whose chief duty is to visit tuberculosis and venereal disease patients and contacts and others who are mentally ill. During this period she spends three mornings visiting and observing the different types of homes from which hospital patients come. She learns of the teaching of prevention as given in the home and gains a knowledge of the importance of racial psychology in relation to habits, customs, traditions, mental and emotional processes and the educational background of these people. Tolerance towards different creeds, nationalities and personalities is stressed. She is taught to listen and to encourage self-expression on the part of each member of a family, to look upon the family as a unit and to realize that more than one problem may present itself, and to encourage these families to solve their own problems. She is told that health and social needs cannot be separated. She attends the chest clinic on three afternoons and the venereal disease clinic on three evenings.

Next comes an excursion to the Sanatorium where the medical superintendent explains and demonstrates laboratory tests and results; the use of x-ray in comparing a normal chest with others in various degrees of disease; personal and ward equipment used in pneumothorax by patients and nurses.

In her third year the student visits two industrial plants, including a manufacturer of woollen goods and a manufacturer of stationery. On arrival, she is met by the industrial nurse and a responsible representative of the firm who explain illnesses and accidents peculiar to the industry. She is escorted through the factory where hazards and safety

devices are demonstrated and questions are answered. The industrial nurse tells of her work among the employees, of her home visits, of preventive teaching and of the care taken of employees who are ill or in need of help.

An afternoon is spent at the Ontario Mental Hospital when the doctors explain the history of twelve patients, each suffering with a different mental disease or disorder. The patients are brought in separately and the nurse observes the behaviour of each. The superintendent of nurses escorts her to various treatment rooms where treatments are seen and results are discussed. The preventive aspect is stressed.

A selected few spend five weeks with the Victorian Order of Nurses. Here the student attends a conference dealing with the fundamentals of public health nursing and the policies of the Order. Community resources are explained as well as the meaning of co-operation and relationship to other public health nurses. She is taught the essentials of a home visit, how to introduce herself as a member of an organization, courtesy, approach to family habits, records, and reports. Prenatal visits are made and she learns about the preparation of the home for a confinement. Delivery technique is explained to her, and the making of post-natal visits which leave the mother with a sense of the urgent need of a periodic check-up for her child at the well baby clinic. Each student writes a case history, making special mention of the needs of a particular family she has visited. After each experience the student is encouraged to write an account of her impressions.

They Need Nurses Too

In a recent issue of the Winnipeg Free Press, Kennethe Haig, a staunch supporter of nurses and nursing, makes some challenging statements and here they are:

It begins to look as though rural Manitoba would have to fall back on the almanac for medical advice. Since the commencement of the war there are 44 fewer physicians outside of the urban centres in the province than there were before. And there is nothing to compel doctors to go to the rural areas.

Rural Manitoba has a few nursing stations and these now as always are doing valiant service. But the unwillingness of doctors to serve in the country is equalled by the unwillingness of the nursing profession. It is stated that nurses too are locating in the cities and it is claimed that it is with the utmost difficulty that one can be secured for a rural case. They are even unwilling to take staff positions in the out of the city hospitals.

There is something to be said in defence of both doctors and nurses for this attitude, but the stark fact remains that there is a definite shortage of medical care in our rural areas. This year has been singularly free of illness but everyone had better keep his fingers crossed. In case of an epidemic the situation might attain catastrophic proportions. In the meanwhile the least the cities can do is to divide the province into areas and set up emergency machinery which might be used in case of dire need in the rural communities. This is as much a war service as any, however enlivened by a snappy uniform.

Low Cost Special Diets

Nan O. Garvock

The rapid strides that have been made in scientific advances and discoveries in nutrition have certainly stimulated widespread interest in this filed. The need to bring a realization of the relationship between nutrition and public health to the minds of the populace is the next step. When that has been accomplished a great contribution will have been made to the social well being of all people, as wide disparity in income will not be so easily tolerated. It is particularly significant that Canada has now set up her own dietary standards for the purpose of establishing minimum basic nutrition requirements by which can be measured the adequacy of the nourishment of its population. It is noteworthy also, that a vast improvement has been made in the food habits of many individuals but it is true that there is yet much ground to be covered.

The section of our people which suffers a great deal is the low income group and the relief recipients and, in spite of the upswing in industry, this number remains great. Having a limited amount to spend for food, they buy what is filling and of course strive to buy what they see advertised. We are taking a leaf out of the advertiser's book and, though not following his methods in entirety, yet our aim is as clear — to bring the principles of nutrition to the public in as simple and practical a way as we can devise. If the application of the principles of nutrition can become fashionable, as there seems to be every indication, we are on our way. The focus at the present time is economy for every one, and is an all-time necessity for those on minimum levels of income. However, once enlightened as to the effects of proper dietary habits, they will develop a new set of eating routines.

I am afraid that when the rates of relief and the level of some of the low incomes that exist are known, the attitude will be that there isn't much use advising the people what to do with the inadequate cash they have and get. Yet the smaller the income, the greater the need of wise spending! Every mistake in the selection of food by those living on these minimum and sub-minimum levels is serious and may lead to some physical deficiency which may take months or years to correct. So we cannot dodge the challenge while we wait for living standards to rise for all.

Related to normal food needs are the therapeutic requirements. The emphasis changes, but the patient's family does not change its needs or attitudes much, nor does the family income change unless perhaps it is reduced. It is an accepted practice in our up-to-date hospital dietary departments to plan special diets in terms of normal requirements. A yet wider application is needed if the purpose of the diet is to be achieved, that of helping the sick to regain their health. Unfortunately there are no free automats from which flow the well balanced scientifically calculated diet essentials. Cash in hand to purchase them is imperative.

Special diets generally call for some expensive food item which could be substituted by a cheaper article without changing the fundamentals of the diet. We still find chicken prominently placed on the diet sheets handed to the patient whose food money is limited. Can you blame him for feeling resentful that he cannot have such luxuries, especially

when a pen has been drawn lightly through them? The cost of many foods varies with the season and the market conditions. A knowledge of these variations is required to plan, often with considerable difficulty, the substitution of foods favourably affected as to price in order to secure palatable and varied diets.

Another problem is that often the daily amount of food making up the diet is larger and has wider variety than the entire family is likely to have over a period of days. Variety and sufficient amounts are desirable, but is it not better to have simple and seemingly monotonous diets which have some of the food essentials provided for each day, rather than to use two or three day's food allowance in one day's requirements? I am reminded of an order which I saw recently and which instructed the patient to have for his breakfast, two eggs and bacon, if desired, with orange juice, coffee and cream, also if desired. Now I ask you, who wouldn't desire such a breakfast?

The ordering of expensive diets by physicians is tied up with their unfamiliarity with actual food costs and cheap substitutes capable of bringing about the same results, as well as with the very limited resources of the clinic patients to carry out their recommendations. The patient looks upon his diet as the one thing that will bring about his cure. If foods which he cannot afford are included, one of two things will happen : realizing that he is unable, because of lack of funds, to buy these foods many of which he has never eaten in his life, the patient becomes discouraged and does not adhere to his diet at all, thus retarding his own recovery; or, at no matter what sacrifice to other members of the family, he insists upon having the exact foods listed, thus forcing other members of the family to go without, or accumulating debt in order to procure the items recommended.

It seems particularly important, therefore, to try to persuade doctors and outpatient department clinics to recommend low cost substitutes for foods on their regular diet lists, and to secure generalized application of low cost therapeutic diets for patients struggling along on low incomes, as well as those on relief. There is the matter of the large quantities of cream required on ulcer diets. Why not use evaporated milk as a substitute? It is about half the cost. Its use in the place of cream is desirable for another reason. The diet needs are taken out of the luxury class and a commodity is suggested that establishes thrifty purchasing as well.

We know that pork, beef and lamb's liver more than equals the nutritional value of the highly priced calf's liver but, if this fact is not made clear to the patient who has been instructed to use liver in quantities, the doctor's orders are not carried out. I cannot resist pointing out the absolute lack of frugality encouraged by the instruction given to many diabetics, to wash the remaining syrup from canned fruit. The result, in addition, is bound to be pretty flavourless.

Among other useful suggestions are purchasing in bulk as general thing; keeping away from fancy packages as that is the expensive way to buy; wider use of molasses; use of skim milk; serving edible weeds when in season such as lamb's quarters, dock and sorrel; use of beet, carrot and turnip tops, making jam at home. All these measures help to keep diets low in cost.

We are now learning the great importance of making the therapeutic diet fit into the general dietary plan for the family. Therapeutic diets are usually only variations from the normal dietary and, by a little careful planning, may be incorporated into the family menu so

that the patient is unaware of any special catering to his needs. Such planning is beneficial to the patient, is less work for the housewife, and cuts down on the strain of a lean purse. A wider service still is rendered : as only the foods that are best for health will be included, the health of the entire family will benefit.

As food experts, we are interested in building up a physically better, healthier and more vigorous population and in developing the best possible dietary which will provide all the nutrients necessary for the maintenance of good health at the lowest possible cost. We are concerned not only with the curative aspects but also with the preventive, thus lessening the number of sufferers, as well as the additional cost. An interesting quotation, made by Clifford J. Barborka, M.D., reads as follows : "A large majority of adult patients who consult the average physician are interested in diets. Food is being recognized as a most important social factor in the life of every human being. Events are occurring today that indicate how international relationships are affected by our universal dependence upon the adequate supply and distribution of food; its cost and distribution affect indirectly but intimately the therapy of every patient."

Twenty-Five Years of Service

After almost twenty-five years of service to the Mountain Sanatorium, Margaret Cameron, superintendent of nurses, is retiring. She first joined the staff on the day that fifty soldier patients of the first Great War were admitted to the Sanatorium for treatment.

MARGARET CAMERON

Her period of service has been most faithful and efficient, and she has had the satisfaction of seeing her nursing service gradually expand from a bedside nursing and disciplinary service to a very highly technical nursing service, including organization for surgery, some of which, beginning with the pneumothorax service and ending with the various types of chest surgery, is very highly specialized.

In the organization of all this new type of nursing service, Miss Cameron has shown herself as a progressive leader and she now leaves the staff with the gratitude of the board and members of the staff for her kindly, co-operative spirit, and with the love and respect of the many patients who have received the benefits of nursing care under her capable direction.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

How the War has Affected Family Life in a Small Canadian Community

CHRISTINE E. CHARTER

This is the fourth year of War. How much or how little have these years meant to the average Canadian home? This article is written from the point of view of a Victorian Order nurse working in a small town, typical of many such, on Canada's eastern coast where the war comes very close. It is a town of sea-faring tradition and has this in common with all other towns—there is scarcely a family who has not sent some member to join the battle for freedom. Grief has come along with improved conditions and herein also lies a tragedy—it has required a war to bring about social changes. Even in a small town the change in the pattern and tempo of life is obvious. For the first time since the depression years, many families are receiving an adequate and regular income. This has resulted in a spirit of independence together with a growing realization of responsibility to home, community, and country.

To the public health nurse who is in close contact with the home life of the community, this spirit shows itself in many practical ways. For example, recognition that all homes are in the front line in the fight against malnutrition has resulted in more effective teaching of the principles of good nutrition. Since there is full-time employment, because of defense work, expectant mothers can, for the first time in their lives, follow dietary recommendations made by their doctors. Mrs. W. in particular, is a good example of the result of better instruction during the prenatal period. She had this year, her first average-sized healthy baby in seven pregnancies. Rationing has, of course, been one of the reasons for this increased interest in food. One father has requested recipes from the nurse which would help them "to use up the sixteen pounds of sugar we have to buy now—we never needed to use half that much before." Needless to say, the system of rationing was carefully explained. Adequate meals for war workers and children alike are becoming the topic of conversation in homes of all classes. A genuine desire is evident to provide the food most beneficial to young growing bodies, and for adults working long hours in defense industries. The need for the distribution of milk and cod liver oil to school children, made possible by a local service club, has been reduced by seventy percent as shown by the increase in weight and general health status of children who

were previously much below par. In this particular area, the problem does not exist of the mother being employed in industry or engaged in volunteer work which might occupy too large a proportion of her time. Therefore, the planning and the serving of family meals are given the attention they deserve.

In many cases, this new sense of responsibility for family life is shown in improvements in the housing conditions. Mrs. M., whose husband is in the Navy, is so proud of her tiny new home, which was built by her father and her brothers by savings from her allowance. Mr. R. is equally proud that he has been able to provide a new sleeping porch for a sick daughter, while the next-door neighbour is also able to enlarge his house and now has a sink and pump in the kitchen to save much hard labour.

A heartening picture of the improvement in the morale of families in the low income group has been clearly shown by the increasing desire to pay for their nursing service. Patients who have received care at intervals over a period of years for part fee or no fee at all, are now proud to be able to pay at least a part, if not full fee. From one young couple, a small cheque was recently received, "for Sally because we just couldn't when she arrived three years ago".

This feeling of responsibility is also resulting in a growing interest in community activities. With the curtailment of pleasure driving, both parents and children are spending more time in the home and parents are showing a greater desire to participate actively in such organizations as the Home and School Club, home nursing and first aid classes, Women's Club and Women's Institute. Through these activities they learn how to give more intelligent direction in the use of leisure time and also how to give better attention to their physical needs.

However, there is another side to the picture, for, although some of the problems of a large city do not exist in our districts, there are still certain difficult situations which have to be faced. The most important of these is the breaking up of family life by the absence of the husband or father in the armed forces. In some cases this has resulted in an emotional and economic disturbance to the wife and children. There has been a lessening of parental discipline and, in the occasional family, the standards have been lowered. This has caused an alarming increase in juvenile delinquency and illegitimacy. Mrs. R's Jim, despite curfew laws and the interest of the Big Brother Group, had to be sent to the Boys Industrial School. Her illegitimate twin babies were boarded out by the Children's Aid Society. The whole town heaved a sigh of relief when Mr. R. was finally discharged from the army as physically unfit and came home to unite the family once more.

Even in communities where there is a boom in employment because of defense industries, not all families are sharing in the prosperity. Some incomes have remained stationary; others have decreased because frequently the husband has given up a more lucrative position in order to be of more service to his country. In these cases, because the cost of living is higher, the family finds it much harder to budget from their allowance. They require special assistance in their planning so that the money available may be spent in the most economical way possible in order to provide a well balanced diet.

The parents in this district are becoming more interested in the welfare of their families and their community. The public health nurse finds an increased interest in health. People are seeing more clearly the need for co-ordination in family activities and that it is

only by maintaining the family as a unit that our Canadian way of life will survive. It has often been said that the things we say we do are better than the things we do. If this is so, and particularly in view of the significant changes in family life, there is a growing conviction that "now is the time to close the gap between the things we do and the things we say we do".

With the Coast Travelling Clinic

FLORENCE M. ERICKSON

European news had just been on the air and, in that world wide round-up, we heard the voices of two women—one speaking from South America, the other from Turkey. It is this sort of thing which makes you realize that this time women are definitely in the front line. This war is making the job of nursing on the public health front more important every day. Can we take it, as those women in the newspaper world so definitely have proved that they can take their jobs? I think so. We can even take it and enjoy it.

As public health nurse in the Coast Travelling Clinic, I recently attended a clinic in Chilliwack. The weather was all blue skies and sunshine. On the most perfect day we held the busiest clinic and my time was spent in rushing madly between histories and x-rays, and the tanks in the dark room. At dinner, I grumbled long and loudly to the local public health nurse about having the entire district trooping in on the same day. She raised the point that the main thing was that contacts had been examined and argued at length.

At the mention of the Chilliwack clinic I remember the thrill of the scene which greeted me each time that I went out to bring in a fresh victim for x-ray. The hall is long and, at the end, is a glass door. Beyond that door stretches a country lane—a dirt road with two ruts and ditches on either side. Flanking them is a snake fence and beyond is a line of poplars, taking on all the fineness of an etching in their winter bareness. Then fields, country fields which go on forever. Where does the road lead to? My eyes never got that far. I was lost in the beauty of the scene. Histories were difficult during that week in the Fraser Valley. Strangers who come to chest clinics, because their own doctors have become suspicious about their chests, are nervous, and nerves play havoc with our memories. I looked away from those men and women while they tried to answer the overwhelming questions which we people in clinics ask of all who enter, and my impatience was lost in the contemplation of a snow-capped mountain.

With the nurses, I talked shop. Get two nurses together and they always do, or so say our critics. But my memories of those conversations are of trips made to the top of the mountains and along the black earth trails of the valleys in between. However, I can catch myself up at a moment's notice and tell you that the public health war on disease, and the preventive defences against further inroads by the enemy, are two front line measures which are being carried out with the greatest efficiency in the

Fraser Valley. Women are doing their part on this front as those women are doing their work in South America and Turkey. In time, nurses' voices will also be heard over the air.

In British Columbia we have three Travelling Chest Clinics working full-time, and a fourth working on the road for one week in every month. In the Coast Clinic we cover the Fraser Valley and, leaving our car behind, pack our equipment on board one of the coastal boats. They all seem to sail at night, in the silvery sheen of moonlight, or the rich glow of a Pacific sunset. The thrill of Seymour Narrows, where the waters swirl around and over Ripple Rock, is saved for the homeward trip. Morning greets us with a narrow green pathway stretching between numerous rocky islands. Here and there can be seen the smoke of small logging camps.

Sometimes our timetable fits in best with the boats which call at every port and we have the excitement of watching everything from plant machinery to home furnishings, automobiles, timber, groceries, crates of ducks, and even cows being hoisted to the wharf below. Each port has its own particular atmosphere. The buzz of the saws, and the exhilarating tang of the newly-cut logs, or the doubtful beauty of the canneries and their own particular tang. At Alert Bay we journey back into the history of early British Columbia. The village, with all its newly-built houses and imposing Indian Residential School, reminds us that the first settlers of the Pacific coast were the North American Indians. The Travelling Clinic examines the children in the school twice a year. To this clinic also come patients from all the surrounding settlements. They take their chances with the storms which crop up from nowhere when the Nimkish, the bad wind, blows.

Beyond Alert Bay, we meet the open Pacific as the boat cuts its way across Queen Charlotte Sound. I once played shuffleboard across that open stretch but on every other trip I have hated the Sound in the privacy of my cabin. Like every other nightmare, it is quickly forgotten in the green, land-locked waters at the mouth of Dean Channel. We sail up this winding waterway to be greeted, around the final corner, by the village of Ocean Falls. It looks like a hanging garden, as each white house has a small patch of green grass, and flower boxes at every window. The roads are made of boards and provide grand watersheds when the rain really falls. Beyond and almost directly overhead is grey rock rising to an immense height. Ocean Falls is a pulp mill community with "company" medical service. The hospital, where the doctors have their offices, is in reality a health centre, and our clinics are large.

From Ocean Falls, we wind our way up narrow channels until the waters widen out where the Skeena River empties into the Pacific. There are still islands everywhere. We swing in, and around them and sail up the long harbour of Prince Rupert which, in wartime, has taken on all the bustle of a large city. I could tell you of the Hospital with its splendid accommodation for the travelling clinic where patients stream in and we even work through Saturday afternoon, but I would rather carry on from the time when the clinic nurse sails out through the harbour entrance, this time the lone passenger on a cannery boat. The captain and his youthful helper take turns in pointing out all the points of interest. With pride they tell me of the huge guns which we can see sticking out from the rocky headlands. We skirt close to the government boat to show our number to these guardians of Canadian waters. Then the little boats appear. They come in

droves around the rocky islands which mark the entrance to the Skeena River Slough. They belong to Indians and when the season is over the fishermen scud into town to spend their money on all the gay, bright things which Indians love. Every boat has a child in a gay coloured coat beside the skipper.

We slow up as we creep past ugly grey rocks. A burly Swede's boat is stuck on a sand bar. Our skipper shouts, "You'll get off in about half-an-hour". Both men know that the tide will need no help in launching the craft, when the right moment arrives. We swing around the last island, and out of the choppy tide-running water into the stillness of the Slough. The left bank is lined with canneries. A snow-capped mountain lures us on to search the mysteries of the Skeena River, but we turn off and wedge our way in between more fishing boats which lie idle only until the gun fires at six o'clock on Sunday night. Then they're off in search of another type of fish the season for which is just beginning. From Prince Rupert we sail north once more, and even cross a scrap of Alaska, before we set up our machine again and get on with the business of x-raying chests.

Coming out to the open sea, the country flattens out, and you wonder if beauty has been left behind and only the barren waste of the Far North is left. These doubts are quickly dispelled as the boat ploughs its way up the Portland Canal. The mountains suddenly rise directly from the water's edge on either side. Schools of porpoises play tag around the prow of the boat, dashing the water up as they make fierce thrusts at each other. As twilight approaches, the snow-covered mountains seem to be stretching out to touch the sky. The tourists guess at their height. I answer 3000 feet, and can't resist adding that I'm going to sleep on top of them tonight. We climb into a car and drive along a winding, flat road which follows the meanderings of a slow moving river. When we have almost decided that the mine must be below the mountains and not on top, the road starts to climb, and leaves no doubt as to where it is bound. Emerging at intervals from the stretches of heavy forests, we find the world at our feet. A world of black ravines and tremendous glacier-clad mountains. Glaciers everywhere reflecting the blue light of the moon. I crawl to bed overpowered by twelve miles of giant's scenery.

There is much work to be done in these mines by the clinic staff. Work, and more work, and under difficult conditions. The developing tanks for x-ray films are small as they are only used once a year, when the clinic visits the mine to make the examinations which are demanded by the Compensation Board. The problem of washing the films becomes a very serious one. The miners come in bunches as the shifts change. We are busier than bees in this search for silicosis, but between shifts, exhilarated by the rarity of the atmosphere, I climb the mountain which harbours the Big Missouri Mine, and, standing there alone, I view the glory of glaciers which come sprawling down between grey rocks with moss-green shoulders. At my feet lies ice—miles of it slowly finding its way down to the sea.

There is work to be done in the public health defences of the home front, in this world-wide war. Because of the splendid response which the medical profession has made in the war effort in British Columbia, doctors are becoming scarce in some parts of the province. This naturally throws a heavier burden on the public health nurses. In the tuberculosis field, it means that the nurses must carry on the greater part of the follow-up work of the patients. Being

ever on the alert, they can detect the signals which signify the necessity of the attention which only a medical man can give. In the search for the source of infection their work is invaluable and, in following the trail of infection which the open case of tuberculosis has spread, they can follow all clues, search for all contacts and thus find the new cases.

These major duties, coupled with routine health instruction, give them an opportunity of playing a very important part in this battle of the home front—the fight against tuberculosis. We nurses of the Travelling Clinics in British Columbia are carrying on but, as you see, our hardest moments are forgotten in the memory of the beauty which surrounds us in every corner of our province.

Front Line Surgery

The Canadian army overseas now has mobile surgical units which follow the fighting men into battle at such close range that urgent surgical operations can be performed an hour or two after a soldier has been wounded. On a recent large manoeuvre by the medical services of the First Canadian Corps, which lasted five days, these new surgical units were tested in the field. Canadian nursing sisters donned battle dress to accompany the doctors of these well-equipped units which worked closely with advancing formations. Four thousand troops were earmarked as casualties, and scores of the more serious cases were "patients" of the mobile surgical units. Equipment of these units was light and portable but, when set up, provided surgical facilities as comprehensive as those in most small town hospitals and as modern as those in almost any Canadian army hospital. One mobile surgical unit went into action on the first day of the exercise. It set up its operation theatre in a tent with a field dressing station and in the first 18 hours performed 15 major operations. Two operating tables were set up, and two nursing sisters, Evelyn Gregory, of Winnipeg, and Margaret Lister, of Calgary, accompanied the surgeons. While one patient was being operated on, a second was being prepared for the knife. The result was practically non-stop surgery.

In order to test this phase of operations, umpires checked each patient as he came, examined the card he carried showing the nature of injuries which he had theoretically received and, from experience, determined the length of time the appropriate surgical operation would require. The patient then remained on the table for the required period, so that the flow of cases would be no more rapid than might be expected in actual warfare.

As the performance of surgical operations automatically immobilizes the field dressing station caring for the patients concerned, the mobile surgical units operated until all beds were filled or cases ceased to arrive, then packed up and moved ahead to a new field dressing station, which had followed up the advance.

The Mobile Surgical Units moved at the end of the first day set up in a new location within twenty minutes of arrival. That same night it moved again to a location still further advanced and, setting up in a tent under strict blackout observance, was ready to receive patients in 35 minutes. The first "operation" was performed at 11.30 p.m. and three more patients were taken care of by 3.30 the following morning. Five hours later, a new ambulance convoy of patients arrived and the dog-tired staff pitched in for a further six hours of surgery.

—*The Gazette, Montreal*

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Adventure in Canton

THELMA Y. CHONG

China has been subject to aggression since 1931 when the Japanese attacked Manchuria. From that time on, many places have been bombed and China has defended herself gallantly. In August 1936, when the Empress of Canada sailed for the Orient, I was on board and the trip across the Pacific was delightful. We stopped over at Honolulu, Yokohama, Shanghai and Hong Kong and from there a coast steamship took us to Canton. Each place was different, new and fascinating, Canton, especially, seemed densely populated. The sidewalks were crowded and often one had to walk out on the road to allow for free motion. Here and there were open markets with provisions and foodstuffs for that particular section of the town. One whole street of stores would be selling the same line of goods, salesmen trying to attract customers by calling out prices. Rickshaws and buses were the main means of communication, there being no streetcars. Autos, mostly open top models with left-side steering wheels and rubber bulb horns, were handled expertly. Winding through the crowds and incessantly squeezing that horn, they seldom had a collision.

November 1936 saw me in a government-established university hospital, ready to take up a position as clinical nursing instructor. The hospital was of lovely Chinese design and green tiled roofs curled up in pagoda style at the corners. It was situated in spacious grounds, had 300 beds and was three storeys high, bordered by trees and fenced in by tall hedges. The floors were made of tile bricks suitable for the humid weather of Canton. The staff doctors were Chinese, all graduates from our medical school, and some had done post-graduate work in Europe. The chiefs of the gynecological, medical, and surgical departments were German doctors who also spoke either French or English.

The nursing curriculum was a three-year course and the students were admitted once a year. Applicants must be at least 17 years old, have a junior high school education, good health, and pass a written examination. The applicants were many but only 25 were accepted, two of whom were male. After a two months preparatory period, they work an eight-hour day with an afternoon off each week. Their clinical experience includes medical, surgical, pediatric, obstetrical and gynecological services, as well as the out-patients department, diathermy, operating room, and laboratory. Due to the fact that there are no western medical terms in the Chinese lan-

guage, the nurses were obliged to learn the diagnoses and drugs in German, and to know the few phrases necessary to assist in a physical examination. Aside from this, all courses were taught in Chinese.

Teaching the nursing principles and practice was quite a problem in that we had to use what equipment we had, some of which was not up-to-date. Teaching in a language different from the one in which you had learned and adapting procedures to the doctors' requirements was not a light responsibility for a young and inexperienced graduate. The calling of special nurses by telephone or messenger and the inspection of the nurses home at 10 p.m. or 7 a.m. was also part of the order of the day. Fortunately being able to speak and write the language simplified matters to some extent. We used a textbook translated from "Practical Nursing", by Maxwell and Pope.

All nurses in China, Chinese or foreign, are governed by the regulations promulgated by an order of the National Health Administration which requires application for a nurse's license before practising. We had eighty nurses, and nine graduates all locally trained, but no house mother. Nurses would sign out with the guard at the gate with a written permit from the nursing school office. In 1936 our nurses lived in several temporary bamboo framehouses but later a lovely home was built for us.

Hospital rates were from $2.00 to $10.00 per day. In each private room there was an extra bed for the "puiyan" who accompanied any patient who liked a member of the family to stay with him. On the bedside table was kept a pot of hot tea or boiled water. All beds were provided with a mosquito net, held up by a round rattan frame hung from the ceiling. At first, sleeping under a net seems suffocating. Patients often refused hospital gowns and insisted on wearing their own padded clothes. Each floor was provided with ward helpers who were the cleaners, waterbearers and errand girls. There was no hot water system and hot water had to be carried by buckets slung on both ends of a bamboo rod placed on the shoulders. These workers are faithful and many stay with the hospital for over twenty years. We had no elevators and stretchers were pulled up the cement runways to the different floors by orderlies, smoothly and quickly. Diets, of course, were Chinese. As food is generally steamed, Chinese cooking requires a special diet kitchen. Our kitchen was operated under contract to a competent group, as was the laundry.

Daily rounds were made by the chiefs and staff, and by the dietician (a qualified graduate of Pekin Union Medical Hospital). Charts were kept in the rooms, written in German. All surgery was performed without masks and no post-operative infections occurred. Tropical diseases were prevalent, such as typhoid fever, cholera, malaria, dysentery, ascaris. Hospitalized tuberculosis cases were mostly advanced. Typhoid fever was not treated with isolation precautions and liquid food was given but not strained. We had only one case of small-pox. Cases of huge tumours and cysts were admitted after having had treatment at home with hot needle therapy — cauterizing spots on the forehead and abdomen — an old and painful treatment still used by some practitioners. Although western medicine is being adopted gradually, the old traditions and customs cannot be easily abolished. Our out-patient department gave prophylactic inoculations for small-pox, typhoid and cholera. There is much to be done in public health nursing, and there will be plenty for we nurses to do to help China in her reconstruction work, already so

successfully initiated by Generalissimo and Madame Chiang-Kai-Shek, in the "New Life Movement".

On May 28, 1938, at 5 a.m. we were awakened by a loud crash and rattling windows. We found the enemy bombers had entered the city and had bombed the Tien Hor Airfield. For weeks, the Japanese perpetrated horrors upon the defenseless civilian population by murderous and indiscriminate attacks, by dropping bombs from high altitudes, and hitting places far from military objectives. Casualties were many, mostly civilians. One cannot begin to describe the types of wounds and injuries brought in by rickshaws, autos, and ambulances. Surgery was busy from morning till night. We recall the drone of bombers above, the anti-aircraft fire, the shiny whistling bombs. One plane came down in smoke but it was only diving in a smoke-screen. As soon as the bombers left, the hospital Red Cross ambulance units went to their respective assigned sections of the city to care for the wounded. Unfortunately, ambulances and hospitals (even with a red cross painted on the roof) seemed to be of no concern to these airmen. One Red Cross ambulance was machine-gunned and forty bullets hit and perforated the car. Whole streets were in ruins, many were homeless. Rescue crews had a gruesome task in excavating the mutilated, dismembered, beheaded bodies that were laid out in rows for identification. The French Hospital on the Bund was bombed as well as the Hackett Medical Center and the New Zealand Presbyterian Hospital.

Air raid alerts came at all hours, especially on moonlight nights. Nurses wore blue gowns under their white uniforms and, at the first air-raid signal, all white uniforms were removed. At night, we went to bed fully dressed except for our shoes and the outer uniform. A flashlight, with a green paper pasted lens, was slung around the neck. Money was kept sewn on our slips. Ward helpers slept on a mat on our bedroom floors so as to be able to help. At the signal, all patients were moved to the ground floor by stretcher, the ambulatory patients followed and very sick patients were moved in their beds to the corridors. During a blackout, the police force might shoot if one was not co-operative in turning out lights.

During the next few weeks casualties were many; the official figures were over 1,500 killed, and 5,500 injured. Our nursing classes were greatly interrupted. One could not sleep well during the night nor relax during the day. that now it seems like a nightmare. Things occurred with such rapidity There was seldom a day when we did not have to move our patients and run out to the zig-zag trenches we dug for ourselves when it was no longer safe to be under a red-cross painted roof. In October 1938, the hospital authorities ordered evacuation to outlying districts. The patients were transferred by relatives as best they could. Three stenographers and I moved to Shameen where we continued Red Cross work. On October 17, 1938, it was again necessary to evacuate. At three in the morning we were on the wharf, each with a suitcase. We boarded a large junk-boat filled to capacity. There was barely standing room so we sat on our suitcases with knees touching the next person. After what seemed a long, long journey we arrived in Macao, a Portuguese colony, in two days. There we learned that Japanese troops had occupied Canton by rail from Waichow.

To add to my misery, I became ill with typhoid, and then with malaria, but a few months later we returned to Shameen to get our few belongings. A permit had to be obtained from the Jap-

anese Consulate in Hong Kong. A Japanese inspector checked us on the boat; he spoke perfect English, was young, well-built and had close cropped hair; he said he had studied in Canada. The boat docked at Pak Hok Tung where a jetty conveyed us to Shameen. At the gangplank a Japanese military official, wearing a mask and carrying a bayonet, stood on guard. Canton was desolate and quiet and looted goods were sold at the waterfront. Our hospital was already being used as Japanese military headquarters.

When in 1939, the Empress of Japan sailed for Canada, I was on board. But the return trip was not so delightful as when we were outward bound. Today, China has as director of the Red Cross Medical Relief Corps Dr. Robert K. S. Lim, an able doctor who has organized units attached to each army instead of to hospitals as in the past. He needs medical and nursing personnel. When the next boat sails for China, I hope it will find me aboard.

Obituaries

Sara S. Macdonald died recently in Vancouver, British Columbia. In 1941 Miss Macdonald retired after rounding out thirty years of service in the Calgary General Hospital, eighteen of them in the capacity of superintendent of nurses. She was a graduate of the School of Nursing of the Massachussetts General Hospital and a member of the Class of 1898. Born and educated in Prince Edward Island, Miss Macdonald was a good citizen as well as a capable administrator. She took a prominent part in the activities of the Alberta Association of Registered Nurses and served that organization as president and as councillor. Her retirement was marked by many tributes from her own staff and pupils, and the community at large, which gave ample proof of the respect and affection in which she was held.

Myrtle Margaret Fielder died suddenly on December 28, 1942, at Detroit, Michigan. Miss Fielder was a graduate of the School of Nursing of the Hôtel-Dieu, Windsor, Ontario. She went overseas as a Nursing Sister with No. 3 Canadian Stationary Hospital, and served in France and Greece. Later, Miss Fielder was Matron at Woolsley Barracks in London, Ontario. For fifteen years, she served as a supervisor at the Receiving Hospital, Detroit. At her funeral, the pall bearers were veterans of the American and Canadian Legions and men of the United States Army.

Elizabeth Hall died recently in Vancouver, British Columbia. After rendering outstanding service as district superintendent of the Vancouver Branch of the Victorian Order of Nurses she became assistant to Miss Mary Ard MacKenzie who, at that time, was Chief Superintendent of the Order. Upon the occasion of this promotion, the officers of the Vancouver Branch spoke of Miss Hall in these terms: "She is a woman of sterling worth and one that the Victorian Order of Nurses may be proud to have on its staff". Miss Hall resigned from the Order in 1920.

Edith McCabe died on January 5, 1943, in Montreal, Quebec. Miss McCabe was a graduate of the School of Nursing of the Royal Victoria Hospital, and a member of the Class of 1920.

Notes From the National Office

Contributed by JEAN S. WILSON,
Executive Secretary, The Canadian Nurses Association

A Proposed Survey of Nursing

At the invitation of the Assistant Director of the National Selective Service (Women's Division), representatives of the Canadian Nurses Association met in Ottawa to discuss nursing problems and the advisability of exercising some type of directive control whereby nursing services throughout Canada could be best utilized toward a total war effort.

This conference was followed immediately by a meeting of the Executive Committee of the Canadian Nurses Association, held in Montreal on October 23-24, 1942, which afforded opportunity for discussion of the proceedings in Ottawa and which resulted in the preparation of a brief setting forth certain proposals in regard to a plan of directive control of nurses during the period of the war.

The Assistant Director of National Selective Service has shown great interest in various adjustments which the Canadian Nurses Association is making on its own initiative through an emergency programme, and particularly in certain actions taken by the Provincial Associations of Registered Nurses whereby nursing services are being conserved and utilized more effectively. Therefore to date no plan for directive control of nurses by National Selective Service has yet been introduced.

On December 29, 1942, with the unanimous approval of the provincial associations and with the advice of the Assistant Director of the National Selective Service, a delegation from the Canadian Nurses Association met in Ottawa with the Executive Committee of the Canadian Medical Procurement and Assignment Board to discuss the advisability of participating in a survey in conjunction with other professional groups concerned with the health services of Canada.

The Canadian Nurses Association delegates were informed that it is proposed that each professional group should undertake a survey of resources and of needs whereby facts relating to supply and demand could be secured; further, with such knowledge available, each group will then make recommendations to meet wartime and post-war needs for consideration by the Federal Government. The delegates on behalf of the Canadian Nurses Association expressed a willingness for the Association to participate in the survey.

It was announced that a representative from each group would meet in Ottawa on January 20-21, 1943, with the Executive Committee of the Canadian Medical Procurement and Assignment Board to discuss the plan of initiating and carrying out the survey. Further developments will be reported in later issues of the *Journal*.

Federal Grant

The grant from the Federal Government to the Canadian Nurses Association for the year 1942 amounted to $115,000 the allocation of which as

specified by the federal authorities was:

1. *Bursaries*: the sum of $25,000 to provide for post-graduate study by which promising nurses may qualify as teachers, supervisors and administrators. In the December 1942 issue of the *Journal* there was published a report of the Bursary Award Committee which showed that $18,000 had been awarded as bursaries to 45 nurses for a year's study at a university school or department of nursing in Canada; the remainder of the amount ($7,000) for the benefit of those nurses who find it necessary to limit post-graduate study to a period of several months only. These short-term courses are offered by university schools and departments of nursing, by hospitals for clinical specialties, and for field experience in public health nursing.

2. *Administration*: the sum of $15,000 for administrative costs arising from the present emergency programme of the Canadian Nurses Association.

3. *Provincial Aid*: the sum of $75,000 allocated to the nine provinces for distribution under the direction of the Provincial Associations of Registered Nurses. This amount provides for financial assistance for (a) a limited number of selected schools of nursing to improve existing teaching facilities and to add to the teaching personnel when necessary, in order to make temporary increase in student enrolment; and (b) public health organizations in providing additional educational facilities and the necessary increased teaching personnel to give instruction and supervision to an increased number of students. Distribution of funds to the provinces is made as specified by the federal authorities, namely:

Alberta	$9,240
British Columbia	$9,900
Manitoba	$9,900
New Brunswick	$3,960
Nova Scotia	$6,600
Ontario	$11,900
Prince Edward Island	$2,000
Quebec	$11,900
Saskatchewan	$7,920

Each Provincial Association of Registered Nurses prepared a budget showing the specific ways in which the grant would be spent. These nine budgets were endorsed by the Executive Committee of the Canadian Nurses Association, then received approval of the federal authorities.

Request For Grant In 1943

The Provincial Associations of Registered Nurses have been notified that a request for a larger grant for the year 1943 has been made. When making a request for an increased appropriation, the federal authorities were informed that the first grant had made provision for a minimum amount of financial aid to the provinces and, in order that the latter may be more adequately prepared to meet their increasing responsibilities toward nursing, a larger grant would be required.

Upon the Canadian Nurses Association receiving a favourable reply from the Government regarding a grant for 1943, each provincial association will then be asked to submit a statement showing the purposes for which financial assistance is desired.

British Nurses Relief Fund

Contributions to the British Nurses Relief Fund have been received from:

Alberta:

Royal Alexandra Hospital, Edmonton, staff & Student Council	$57.50
Calgary General Hospital staff	40.00
University Hospital staff, Edmonton	34.75
Ponoka District No. 2	30.00
Red Deer District No. 6	16.00
Medicine Hat District No. 4	55.00
Calgary District No. 3	39.00
A.A., Calgary General Hospital	200.00
A.A., Vegreville Hospital	5.00
Stettler Graduate Nurses Group	20.00
Country Hospitals	27.32
Individual donations	42.75

Manitoba:

Mrs. E. F. McMahon	10.00
Students Council—St. Boniface Hospital	50.00
The Pas Graduate Nurses Association	5.00
Scarth Homemaker's Club	14.89

New Brunswick:

Nurses of St. Joseph's Hospital, Saint John	7.00
Nurses of Provincial Hospital, Saint John	17.00
Nurses of Tuberculosis Hospital, East Saint John	32.50
Nurses of Saint John General Hospital	42.00
Nurses of Lancaster Hospital, West Saint John	22.00
Private donations	12.50
Public Health Section, Saint John	30.00
Private duty nurses, Saint John	15.00
Private duty nurses, Moncton	32.80
Student Nurses, The Moncton Hospital	10.00
A.A., Hôtel-Dieu Hospital, Campbellton	8.00
New Brunswick Association of Registered Nurses	100.00
Fredericton Chapter, N.B.A.R.N.	48.50
Staff nurses, Victoria Public Hospital	8.75
Student nurses, Victoria Public Hospital	5.40
Nursing Sisters, Sussex Military Hospital	15.00

Ontario:

Districts 2 and 3:

A.A., St. Joseph's Hospital, Guelph	36.00
Walkerton Graduate Nurses Association	50.00
Simcoe Nurses Registry	20.00

District 4:

Nurses of St. Catharines	49.00

District 5:

A.A., Toronto General Hospital (Nov. & Dec.)	250.00
A.A., Grant Macdonald School	100.00
A.A., Toronto Western Hospital	38.45
Student nurses, Wellesley Hospital, Toronto	100.00
Brampton Nurses	12.50

Matron and Nursing Sisters:

Chorley Park Military Hospital	30.00
Camp Borden Military Hospital	21.00
Graduate Nurses Association, School of Nursing, University of Toronto	10.00

District 6:

Port Hope Hospital nurses	18.00

District 7:

Perth nurses	6.25
Brockville nurses	92.30

District 9:

Graduate nurses, Sioux Lookout	10.00
New Liskeard nurses	153.50
Student nurses, Plummer Memorial Hospital, Sault Ste. Marie	25.00

District 10:

Fort William Sanatorium nurses	5.00

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada :

Miss Janet Holder, a graduate of the Royal Victoria Hospital, Montreal, *Miss Sylvia Davidson,* a graduate of the McKellar General Hospital, Fort William, *Miss Camilla Gibson,* a graduate of the Halifax Infirmary, and *Miss Eleanor Fendley,* a graduate of the Saskatoon City Hospital, having completed two months supervised experience on the Montreal staff preparatory to Victorian Order work, have been posted respectively as follows: Liverpool, Oshawa, Yarmouth and Sydney.

Miss Margaret Payne, a graduate of the Saskatoon City Hospital, has been appointed temporarily to the Truro staff.

Mrs. Piirainen (Doreen Sherman) a graduate of the Western Hospital, Toronto, and of the course in public health nursing, University of Toronto, has been appointed temporarily to the Sudbury staff.

Miss Priscilla Annable, a graduate of the Toronto Hospital for Sick Children, has been appointed temporarily to the Toronto staff.

Miss Elizabeth George, previously on the staff of the Yarmouth Branch, has been appointed nurse-in-charge.

Miss Helen Carpenter, assistant superintendent of the Toronto Branch, has been granted a leave of absence and is attending Teachers College, Columbia University.

Miss Luella Harrigan has resigned from the Guelph staff and has accepted a position with the Department of Health in that city.

Miss Sadie Wright has resigned from the Winnipeg staff.

Miss Marjorie Scarr has resigned as nurse-in-charge of the New Glasgow Branch to serve with the R. C. A. M. C. Nursing Service.

Miss Marjorie Hollister has resigned from the Toronto staff.

Miss Marguerite Grossmith has resigned from the Toronto staff to be married.

Miss Eola Scott, previously in charge of the Branch in Chatham, Ontario, has been transferred to the recently opened Branch in Welland as nurse-in-charge.

Miss Catherine Maddaford has been transferred from the Peterborough staff to the Welland staff.

Miss Mary Ellen Patterson has been transferred from the Border Cities staff to the Chatham Branch as nurse-in-charge.

Miss Mary Allen has been transferred from the Sydney staff to the Dartmouth staff.

A New Appointment

Flora Aileen George has been appointed Matron of Ste. Anne's Hospital (Department of Pensions and National Health) Ste. Anne de Bellevue, P. Q., a military hospital of 1500 beds. Miss George is a graduate of the School of Nursing of the Sherbrooke Hospital and took the course in teaching and administration in schools of nursing, given by the McGill School for Graduate Nurses. Later, she became lady superintendent of the Woman's General Hospital in Montreal, a position which she held for eight years until she was appointed director of the Nursing Service Bureau sponsored by the A.R.N.P.Q. For the last two years she has rendered valuable service as general superintendent of the Victoria Public Hospital, Fredericton, N. B.

Miss George is actively interested in the work of nursing organizations and has served the A.R.N.P.Q. as a member of the board of managers, and of the board of examiners, as well as chairman of the hospital and school of nursing section. Her many friends welcome her back to her native Province and wish her all success in the important task for which she is so well qualified.

STUDENT NURSES PAGE

We used Ourselves as Models

FLORENCE ARMSTRONG

Student Nurse

School of Nursing, The Children's Hospital of Winnipeg

Some time ago our class put on a symposium on diabetes in correlation with our lectures in medical nursing. All my classmates took part and the junior class of our year was invited to attend. As the students entered, they found one end of the room screened from view. Behind the screen, we had set up the equipment necessary to demonstrate the nursing care of a diabetic patient and our leader introduced the symposium by reviewing the anatomy and physiology of the pancreas with the use of diagrams. Then came an outline of the pathology, and of the causes and symptoms of diabetes mellitus.

As the screens were drawn aside, the onlookers saw the "patient", (our classmate) lying in bed in a condition of what appeared to be severe diabetic coma. Her respirations were characteristically Kussmaul in form, and she was obviously semi-comatose. One of the students demonstrated the nursing care of a patient in diabetic coma. The points in bedside care included methods of relieving dyspnea, the application of external heat, and special care of the mouth and skin. The temperature was taken per axilla. The importance of obtaining specimens of urine was stressed, and the problems involved in this connection, when a patient is in coma, were discussed.

Our "treatment nurse" then demonstrated an urinalysis. As a diabetic urine specimen could not be obtained, honey

Making an urinalysis

Administering an intravenous

and acetone were added beforehand to cause a positive sugar and acetone reaction. The diacetic acid reaction turned out to be negative as we could find nothing that would cause the change in colour which accompanies a positive reaction. The preparation of an intravenous, containing 5 percent glucose in normal saline, was then demonstrated and our treatment nurse reviewed the various types of insulin and considerations in their administration. Our "dietician" emphasized the importance of a carefully regulated diet in the subsequent management of the diabetic patient, and actually weighed out the food for a prepared diet.

Our symposium ended with a general discussion of possible pitfalls for our "patient" and the various aspects of specific health instruction, which are so very important in diabetes mellitus, were discussed. It was decided that she should be taught the principles of dietary and insulin management and of urinalysis so that she could gain independence. The importance of scrupulous care of the skin and of avoiding infection was emphasized. For future emergencies, it was decided that she should carry on her person a card stating that she was a diabetic, in case of a second occurrence of coma, and some form of sugar to treat the early symptoms of insulin shock.

We had previously studied diabetes in its various phases and had found it an interesting subject. But the few days spent in the preparation of our symposium gave us a much greater appreciation of the value of intelligent nursing care to the diabetic patient. The actual demonstration of each step in the treatment and nursing care of this condition was of greater value to us than mere discussion. It gave us a lasting impression, so that when we meet our first real case on the hospital wards we shall be able to give the more intelligent nursing care for which we are striving.

A Student's Viewpoint on Clinical Teaching

MARY KNIGHT

Student Nurse

School of Nursing, Saskatoon City Hospital

The Saskatoon City Hospital School of Nursing holds daily clinics, except on Sunday, for student nurses. About twenty students are present at each one, and all are free to ask questions of the patient, who is the guest of honour. The patient is chosen because he presents a typical clinical picture of some particular condition, such as leukemia, cirrhosis of the liver, a brain tumour, schizophrenia, or even some surgical condition, for example gastrostomy. The students, an instructress and an interne gather in the patient's room; the procedure has been explained to him beforehand and his co-operation assured. Guided by questions from the interne, the patient tells the students about his symptoms, when they first occurred, what they were like, whether or not they were severe. We are shown any demonstrable ones, such as the intention tremor of paralysis agitans, or we are allowed to feel the water-hammer pulse of the enlarged syphilitic heart. By hearing from the lips of a patient the manifestations of the disease in himself and applying to it our own knowledge, aided by that of the interne, the whole clinical picture is put before us. After meeting the patient and talking with him, we all retire to another room where the theory of the condition is given. The interne deals simply with the pathological development and medical side of the disease, while a number of student nurses contribute short talks on the treatment, nursing care and history of the patient.

To illustrate, let me summarize briefly a clinic held recently on Parkinson's disease, technically known as paralysis agitans, or, commonly, shaking palsy. We visited this patient, and found him an intelligent man of fifty years of age, who until two years previously had been in optimum health. At that time, he told us, he noticed a tingling restless feeling along his legs, which, over the space of a few months, spread up over his body into his left arm, and then lastly, though not as markedly, into his right arm. He began to notice a tremor in his hands, in which the fingers were constantly moving down the thumb in a "pill-rolling fashion". As he showed us, it could be stopped voluntarily when he went to pick up some small object. His eyes were slightly protruding and staring. His speech was inclined to be a little thick and hesitant. When he walked, he leaned forward slightly, his head and spine bent together, which helped to cause a queer forward shuffle, almost as though his feet could not keep up to his body, and his movements were jerky as though his limbs were rigid. Here was a typical Parkinson's—one we would not forget.

After we left Mr. X, the interne explained that this was a chronic progressive disease of the nervous system, characterized by what we had seen in our patient—tremor, muscular rigidity, and peculiar changes in posture, facial expression and gait. He explained the etiology, the precipitating causes, and how the lesions themselves are caused by degenerative, atrophic, or inflammatory changes in the striate body and globus

pallidus ganglia at the base of the brain. Following this, a student nurse gave a paper on the symptoms and pathology of the disease and a second student dealt with the progress, complications and prognosis. Here we learned that although it may take thirty years to reach the final stage, the prognosis is never good. A third nurse discussed the general treatment which includes warm baths, proper nutrition, and sufficient rest with the addition of sedatives used to quieten the tremor and help relieve general weakness. The fourth student dealt with the nursing care given to Mr. X, which included the mental aspect as well. Freedom from anxiety is all-important.

On the whole, we students feel that such a clinic, conducted in such a manner, is most beneficial. We are presented with a series of pictures of pathological conditions that we will always remember. Behind those pictures we are aware of the causes and effects as explained to us by medical science. Here we have found the connecting link between our practice and its theory and, every day, new fundamental knowledge and understanding become more closely intertwined with our common procedures. This enables us to give our patients a maximum of sympathetic and intelligent nursing care—and is this not our aim?

The following comment on the preceding article is offered by Mrs. G. Dale, assistant director of nursing, the Saskatoon City Hospital:

For some years past our educational programme has included clinics. These were valuable and interesting, but not as valuable or as interesting or as educational as they should have been because they were "more or less" conducted by an instructor in connection with classroom lectures. Early this year we began an educational programme which has proved itself truly valuable and, better still, the students actually enjoy taking part and preparing the material. Other students from any part of the hospital are invited to attend and do so in numbers of from ten to twenty each day. Graduate nurses, internes, and quite often a dietitian and a physiotherapist are present. All may and do contribute.

These programmes consist of bedside clinics with demonstrations and informal round table discussions of nursing care studies, and also observation studies—the latter prepared by students in the admitting department who do follow-up work on the ward before submitting the finished material for discussion. These clinics are under the direction of our ward supervisor who enlists the aid of an interne, a dietitian or physiotherapist, or indeed anyone who may be necessary in each particular instance.

This educational programme was organized and is under the direction of the assistant director of nursing and is carried out as follows: one week in advance, each supervisor reports to the assistant director of nursing which patient is being studied and a date and place is then arranged. On the day assigned, a blackboard and other teaching material is made ready for our "1 p.m. clinic" which lasts from a half-hour to one hour. The nursing care study is prepared by four different students, the outline being usually as follows: first nurse—the disease in itself; second nurse—treatments, complications; third nurse—the patient himself, his history, admission, dietary problems and treatment; fourth nurse—health teaching and general discussion. This outline is flexible, and may be changed somewhat to suit each individual case. One can readily understand that it is not so much the written material submitted as the questions and discussion which arise from it that are valuable. Later, our most interesting clinics are typed and put in folders in our library, dated so that when being read for reference in the future any material regarding new medications and medical discoveries may be added. The text "Ward Teaching", by Anna M. Taylor, M.A., R.N., has provided much valuable help in organizing this form of clinical teaching.

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*Suggested by National Research Council—not official.

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Nursing in Chungking

L. Clara Preston

I had often wished to go to the Province of Szechwan on a nurses exchange plan so I appreciate the chance I now have of helping with nursing work in Chungking although I regret the circumstances that have made it necessary. Nursing in the North can hardly be compared to a war-conditioned program in the West. Formerly, Chungking was just one of our West China mission stations—now it has become part and parcel of my life and it thrills me every time I go into the city to see the amazing courage and hope displayed by these wonderful people.

About eight years ago a fine new Canadian hospital was built on the south bank of the Yang Tse River. The city premises had been outgrown and at that time many people thought that patients would not come so far; but many times since we have been grateful for the present location as it is situated in the so-called safety zone which so far has protected the buildings and the patients from devastating bombs. Seeing the wrecks of other hospitals and the difficulty they have in obtaining new equipment, we are deeply thankful for our fine buildings and the residences for both foreign and Chinese staff.

Because drugs and equipment are so hard to obtain, we are learning how to care for and make better use of what we have and are finding new and cheaper substitutes for many things that are either too expensive or not obtainable. Necessity is the mother of invention and the pharmacy department of the West China University is producing useful drugs made from native products. Large orders of hospital supplies have been bought and must be paid for and yet sometimes they never reach us on account of the difficulties in transportation. Our gratitude goes out to those who have made it possible to give hospital care to many refugees and orphans.

As the wartime capital of China, Chungking has many interesting residents and visitors and we have an opportunity to meet some of them from time to time. Our patients come from all the provinces in China and from many different countries in the world outside and we have heard many thrilling stories of their experiences since 1937. We are thankful for a respite of a few months without air-raids. These are terrifying and cause a dreadful loss in human lives and material things, and are a hindrance to the recovery of the patients. In these times, the members of our staff change more than usual, and lack the spirit of "this is our hospital". Because the cost of living is so high, money plays a big part, especially for those who have relatives depending on them. The indifferent, inefficient coolies constitute one of our chief difficulties. High wages and the great demand for workmen of all kinds make them hard to manage and to keep. A great many have also been conscripted for war service. Practically none of them are Christian.

Our nursing school is under the authority of the educational department of the government, and a heavy curriculum is required. Emphasis is placed on theory rather than on practical work. Books, formerly bought from Shanghai, are now not obtainable. Air-raids made classes irregular. Food is expensive and there is a lot of anemia among our students. The majority come from

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Applicants must be unmarried or widows without encumbrances, general trained State Registered Nurses, and must have held the post of Theatre Sister in some recognized hospital or have been responsible for the management of an operating theatre.

Application forms and further particulars may be obtained from the Executive Secretary of the Canadian Nurses Association, 1411 Crescent Street, Montreal. Applications on the forms provided, accompanied by the documents asked for therein, photographs, and recent testimonials, should be forwarded, by **air mail**, to:

The Secretary
General Hospital
Barbados, B.W.I.

WANTED

Applications are invited from registered nurses for General Duty in a Tuberculosis Sanatorium of 360 beds. When writing please state previous experience, age, etc. The salary offered is $75 a month, with full maintenance.

Address applications to:
Miss M. L. Buchanan, Superintendent of Nurses, **Royal Edward Laurentian Hospital (Ste. Agathe Division)**, Ste. Agathe des Monts, P.Q.
(Formerly — The Laurentian Sanatorium)

WANTED

Applications are invited for the position of **Class Room Instructress** for a 100-bed Hospital. Apply, giving qualifications, experience, and salary expected, to:

The Superintendent, General Hospital, Dauphin, Manitoba.

WANTED

Applications are invited from registered nurses for **General Duty** in a **Tuberculosis Sanatorium** of 700 beds. When writing please state previous experience, age, etc. Good salary, with full maintenance. **Excellent living** quarters. Address applications to:

Miss E. Ewart, Superintendent of Nurses, Mountain Sanatorium, Hamilton, Ont.

WANTED

A Superintendent is required for a 39-bed Hospital in **Southern Manitoba.** Applicants must be **Graduate Registered Nurses** with experience in administering ether anaesthesia. The salary offered is $100 per month with full maintenance. Apply, stating age, qualifications, and when available, to:
The Secretary, The Freemasons' Hospital, Morden, Manitoba.

other provinces and are refugees; many of them can get no news of their families and have no means of support. In our last class of twenty pupils, only four were from Szechwan province. Life is hard for them but they have stood the strain of constant bombing with a calm and courage that has amazed me.

This year, the newly graduated nurses are conscripted by the government for one year of service and we are only allowed to keep fifteen percent of them. Girls finish their three years of high school when they are from fourteen to sixteen years of age. They are too young for nursing and go into other work. Those who can afford six years of high school have more attractive opportunities open to them. Courses in public health and obstetrics for graduate nurses are sponsored by the government and we hope that a two-year course will soon be offered in Chentu for teaching in schools of nursing. A very fine meeting was held in Chentu by the Nurses Association of China for the benefit of those in the unoccupied area of China.

Although our nursing work presents many problems it has never been more interesting nor have we ever had greater opportunities in both medical and evangelistic work.

Overseas Nursing Sisters Association

The following officers have recently been elected by the Overseas Nursing Sisters Association of Canada: President, Miss Irene Barton, Deer Lodge Hospital; first vice-president, Miss Elsie Wilson, Winnipeg; second vice-president, Mrs. Clark Davidson, Winnipeg; third vice-president, Mrs. C. A. Young, Ottawa; secretary-treasurer, Miss Anne F. Mitchell, Suite 6, Yale Apts., Colony Street, Winnipeg; representatives from local unit: Miss Edith Hudson, Miss Emily Parker.

Calgary Unit recently completed a very successful "draw" for a Gissing picture, the proceeds to be given to the British Nurses Relief Fund; contributions have also been made to the Fund for British Mine Sweepers.

Mrs. A. G. Cotterell, a former member of the Winnipeg Unit, has taken up residence in Calgary. Mrs. H. Beachinor is now on the staff of the Belcher Hospital. Nursing Sister Margaret Hodgson, who has returned from service abroad, was a guest at the Remembrance Day reunion of the Unit.

Edmonton Unit: A recent cheque for $200 brought the total contribution to date to the British Nurses Relief Fund to the one thousand dollar mark.

Many other activities keep this busy Unit on their toes such as contributions to other war services and the Merchant Marine. Three members of this Unit have become grandmothers during the year.

The *London Unit* is holding monthly bridges to raise money for the British

Nurses Relief Fund. Nursing Sister Edna Waugh has returned from duty overseas.

Ottawa Unit: Miss Gertrude Halpenny has been appointed welfare supervisor with the Dependents Allowance Board, with which Miss Jean Bowie is also associated. Miss Ethel Bagnell is welfare supervisor for the civilian personnel at Naval Headquarters. Miss Emily Schryer, welfare supervisor at the Bureau of Statistics, is taking a course in industrial nursing in Toronto.

Winnipeg Unit: Miss Emily Parker and Miss Catherine Madden recently took observation courses in public health nursing in Eastern Canada. Miss Stella Pollexfen is doing personnel welfare work with the McDonald Aircraft.

Time Savers for Nurses

Times have changed—as these regulations that were put into effect at Stanford University Hospitals indicate. They are designed to save the time and strength of overworked nurses and have proved satisfactory, says Anthony J. J. Rourke, superintendent:

The usual procedure of keeping nursing bedside notes will be discontinued. Nurses will make bedside notes only when specifically ordered by the physician or when some definite change or serious symptom has occurred in the patient.

Present regulations regarding the periodic charting of temperatures will be discontinued. Temperatures will be taken twice daily: once during the morning hours from 7 to 9 and once during the afternoon hours from 4 to 6. When a record of patients' temperatures is desired more often than this, they will be taken on written order of the physician in charge of the case.

The usual daily bathing of patients cannot be continued. Patients will be bathed in bed only as often as necessary, and patients will be requested to bathe themselves as soon as their condition warrants such requests.

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NEWS NOTES

ALBERTA

PONOKA:

The first meeting of the Fall session of Ponoka District No. 2, A.A.R.N., was held recently, with 11 members present. Miss Margaret Lefsrud was elected as collector for the British Nurses Relief Fund. She takes Miss Karen Westerlund's place, who resigned to take a position at the Colonel Belcher Hospital in Calgary. Miss Beattie was nominated by Miss Leckie as a member of the Council of the A.A.R.N. for 1943-1945. With Miss Beattie's consent her name has been submitted to the chairman of the nominating committee. Miss Beattie reported on the plans for refresher courses which are to be offered at the University of Alberta in the near future. She also spoke of the bursary for graduate nurses which is being offered by the Dominion Government.

Several of the nurses are anxious to take a course under the St. John Ambulance Association, and Mrs. Miles has kindly consented to give us the course.

EDMONTON:

Royal Alexandra Hospital:

The annual meeting of the Royal Alexandra Hospital Alumnae Association was held recently. The retiring president, Miss Laufey Einarson, gave an excellent report on the year's activities. In March the annual banquet was held at which a scholarship of $250 was awarded to Miss A. Swift for post-graduate study at the School of Nursing, University of Toronto.

Our two main objectives were war work and the scholarship fund. Two dances were held and $40 was sent to the Milk for Britain Fund and $25 was donated to the "Aid for Russia" Fund. The remainder was placed in the scholarship fund. Afghans were made and set to Britain and to the Seamen's Hostel in Halifax. The members have made thousands of dressings for the Red Cross.

The following officers have been elected to serve during the coming year: Honourary president, Miss M. S. Fraser; president, Miss Mae Griffith; first vice-president, Miss Violet Chapman; second vice-president, Mrs. J. White; recording secretary, Miss E. Perkins; corresponding secretary, Miss M. Edgar; treasurer, Miss I. Toby; conveners of committees: program, Miss K. Stackhouse; benefits loan, Miss A. Anderson; visiting, Miss A. Mc Gillivary; scholar-

ship, Miss L. Einarson; news letter, Miss H. Smith; representative to *The Canadian Nurse*, Miss V. Chapman; executive: Miss Holm, Mrs. Baird, Mrs. Blacklock.

At a regular meeting of the Alumnae Association of the Royal Alexandra Hospital Section Officer Fulmer, R.C.A.F. (W.D.) gave an interesting insight into the work of that organization. The members made Red Cross dressings and patches for quilts.

The dance recently sponsored by the Alumnae Association was a financial and social success. The reception rooms were decorated gaily with flags. Miss Margaret S. Frase., the superintendent of nurses, received the many guests, with Miss Laufey Einarson, president of the Alumnae Association. Miss Violet Chapman was in charge of the arrangements, assisted by Mrs. Alex Baird, Miss Kay Bwell, Miss Nancy Syvolus, Miss M. Boyhaychuk, Miss Betty Chinn, and Miss G. Williams. The proceeds went towards war work and the scholarship fund.

University Hospital:

The Alumnae Association of the University Hospital recently held a meeting in the new student nurses sitting room, St. Stephen's College. Each member contributed a book toward the student nurses library. A committee was formed to take charge of packing Christmas hampers, including Mrs. N. Pound, convener, Mrs. J. Ward, and Mrs. H. Banks. Twenty-five dollars was voted towards the Russian aid fund, and $5 towards the Milk for Britain fund.

MANITOBA

BRANDON:

At a recent meeting of the Brandon Graduate Nurses Association the president, Mrs. S. Perdue, was in the chair. Miss D. Robertson, of the public health unit, reviewed the history of public health nursing, and gave a comprehensive report of the housing conditions existing in Brandon at the present time. Interesting health films concluded a very worthwhile evening. The downtown group were in charge of the meeting.

NOVA SCOTIA

KENTVILLE:

A regular meeting of Valley Branch, R.N.A.N.S. was held recently at the home of the president, Mrs. P. Webster.

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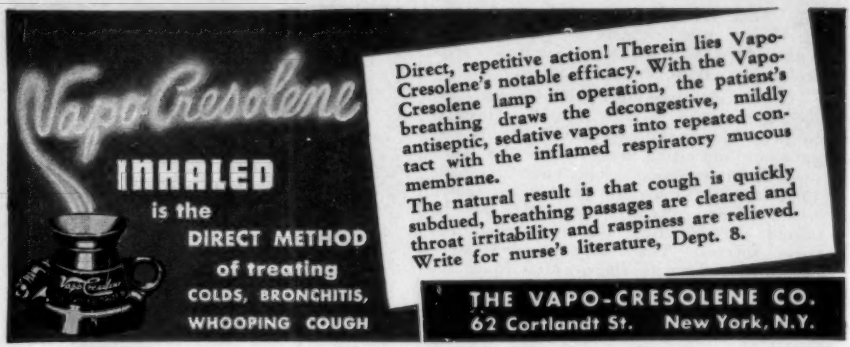
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Miss A. E. Richardson has resigned her position as superintendent of the Blanchard-Fraser Memorial Hospital. Miss Marguerite Richards has resigned from the Blanchard-Fraser Memorial Hospital staff.

Married: Recently, Alma Beck (P.M.H., 1941) to William Bruce.

NEW GLASGOW:

Mrs. La Verne MacEachern, who recently resigned as instructress of nurses at Aberdeen Hospital, was presented with gifts from the staff and students at a party held in the nurses home.

Married: Recently, Miss Ruth Davison (A.H., 1942) to Pte. Charles A. Higgins.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, 135 St. Clair Ave. W., Toronto.

DISTRICTS 2 and 3

BRANTFORD:

There was a large attendance at the first meeting of the New Year of the Alumnae Association of the Brantford General Hospital. Miss Madalene Baker, of London, was the guest speaker. She came to Brantford to assist in the establishment of an organized central registry. The list of recommendations sent out to private duty nurses was also discussed in full. Much helpful information was gained from Miss Baker's talk and a committee was appointed to study and further the purpose of establishing a registry. A social hour followed.

DISTRICT 5

TORONTO:

Wellesley Hospital:

The following officers have recently been elected by the Alumnae Association of the Wellesley Hospital to serve during the coming year: honourary president, Miss Elsie K. Jones; president, Miss Alleen Steele; vice-presidents, Miss Grace Bolton, Miss Doris Stephens; corresponding secretary, Miss Margaret Russell; assistant corresponding secretary, Miss Dorothy Arnott; recording secretary, Miss Elsie Turner; assistant recording secretary, Miss Hermione Wark; treasurer, Miss Jean Brown; assistant treasurer, Miss Doris Goode; custodian, Miss Dorothy Fatt; auditors, Miss Edith Cowan, Mrs. Grace Gundy; Elisabeth Flaws Scholarship Fund convener, Mrs. Dorothy Bull.

The auxiliary sent 785 articles to the Red Cross and made 100 articles for refugees, as well as 14,260 dressings. Six hundred and sixty-nine knitted articles were sent to Canadian and British sailors and 209 to the Red Cross. To evacuee children in England, 260 pounds of clothing were sent.

An identification bracelet was presented by Miss Jean Harris, retiring president, to Nursing Sister Wilma Howes, R.C.N., who will serve on the East Coast. Letters of appreciation regarding the safe arrival overseas of nurses' Christmas parcels were read. The films "The Thousand Days" and "There too, go I" were shown.

DISTRICT 8

OTTAWA:

University of Ottawa:

This year, in order to assist hospital administrators, supervisors and school administrators whose duties do not permit a lengthy leave of absence but who ambition educational progress, the University of Ottawa School of Nursing has offered ex-

tension courses in hospital administration, floor supervision and school administration. The first course was in hospital administration given from October 5 to 20, inclusively, and was attended by seven full-time and three part-time members. It included lectures, round tables and field trips on such aspects of hospital administration as fundamentals of hospital organization, food service, hospital accounting, liability insurance requirements for hospitals, organization and management of the smaller hospital, health insurance, plant maintenance, prevention and control of infection in hospitals, organization re: air raid precautions, hospital housekeeping, hospital ethics, hospital personnel, the admitting office and collections, public relations, and public education. The second course, held from November 2 to 17, was in school administration and floor supervision. Six members attended. The course included lectures, round tables and field trips in the following subjects: development of nursing education, organization in a school of nursing, the school faculty, the philosophy of nursing education as applied to clinical experience, the ward as the laboratory to the school of nursing, efficiency methods versus case assignment in the care of patients, nursing case studies, tests and measurements, vocational guidance, ward manual as a teaching tool, educational value of bedside clinics, efficiency rating of students, jurisprudence, qualifications and qualities of the supervisor, personality traits and attitudes of the good nurse, and the auxiliary worker. These courses are to be repeated as follows: Hospital administration: January 18 to February 2, and March 8 to 23; floor supervision and school administration: February 8 to 23 and May 10 to 25, 1943. During the month of January a refresher course in public health has been planned.

PRINCE EDWARD ISLAND

Nursing Sister Mary Winnifred MacNutt has been awarded the Royal Red Cross (First Class) as announced in the New Year's Honours List. She joined the Nursing Service of the R.C.A.M.C. shortly after the outbreak of war and has served in Newfoundland, in Gaspé, and in other parts of Canada. She is a graduate of the School of Nursing of the Prince Edward Island Hospital and since her graduation has been a member of the nursing staff of the Provincial Sanatorium in Charlottetown. Her fellow nurses heartily congratulate her on this well deserved honour.

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REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA
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An examination for the title and certificate of Registered Nurse of British Columbia will be held March 23, 24 and 25, 1943.

Names of Candidates for this examination must be in the office of the Registrar not later than February 23, 1943.

Full particulars may be obtained from:
EVELYN MALLORY, R.N., Registrar
1012 Vancouver Block, Vancouver, B.C.

THE MABEL F. HERSEY SCHOLARSHIP

The Alumnae Association of the School of Nursing of the Royal Victoria Hospital, Montreal, announces that applications for the Mabel F. Hersey Scholarship will be received. This scholarship is open to any graduate of the Royal Victoria Hospital Training School for Nurses for post-graduate work to be taken in any University School of Nursing, or in any approved hospital in Canada, and has a value of $250. Application forms may be obtained from the Convener, Committee of Selection, Miss Winnifred MacLean, Royal Victoria Hospital, and should be returned to the Convener not later than April 1, 1943.

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QUEBEC

MONTREAL:

Montreal General Hospital:

The annual meeting of the Alumnae Association of the Montreal General Hospital took place recently. The reports of the year's work were most gratifying and the financial statement showed a most creditable balance.

The following officers were re-elected for 1943: Honourary members: Miss Rayside, O.B.E., Miss Jane Craig; honourary presidents: Miss J. Webster, O.B.E., Miss N. Tedford; president, Miss C. L. Anderson; first vice-president, Miss B. Burch; second vice-president, Miss M. Long; recording secretary, Mrs. Norman Brown; co. responding secretary, Miss Mabel Shannon; treasurer of the Alumnae Association and secretary-treasurer of the Mutual Benefit Association, Miss Isabel Davies; executive committee: Miss M. K. Holt, Miss A. Whitney, Miss H. Bartsch, Miss Elizabeth Robertson, Mrs. F. Johnston; general nursing section: Miss A. Whitney, Miss Margaret McLeod, Miss C. Pope, Miss Jean Ross; representative to *The Canadian Nurse*, Miss C. Watling; representatives to the Local Council of Women: Miss A. Costigan, Miss M. Stevens; sick visiting: Miss M. Ross, Miss B. Miller, Miss H. Christian; program committee: Miss Batson, Miss Denman, Miss Annesley; refreshment: Miss K. Clifford (convener), Miss A. Scott, Miss K. Miller, Miss B. Gardner, Miss J. Anderson.

Miss Elma Darling (1941) is serving with the R.C.A.M.C. as Nursing Sister. Miss Barbara Broadhurst (1940) has been appointed to the nursing staff of the T. Eaton Company, Montreal. Miss Carmen Budd (1923) is doing industrial nursing at one of the defence industries plants in Montreal. Mrs. Tait (Edith Little, 1939) is doing industrial nursing in Brownsburg. Mrs. Harding (M. McCallum, 1923) is engaged in school nursing in Toronto. Miss Kay Derby (1942) has been appointed to the staff of the Central Division. Miss Jane Molson (1942) is doing general duty at the Western Division. Miss F. Jean Campbell (1939) of the Western Division is taking a post-graduate course in the operating room, Central Division.

The following marriages have recently taken place: Mary J. Seeley (1939) to Louis de G. Tremblay; Alice B. Finnie (1940) to Flight-Lieut. Ross B. Walker, R.C.A.F.; Mary C. Kobayashi (1941) to Sgt. Maurice Hecht, R.C.A.F.; M. Evelyn Walker (1940) to Cpl. Arnold A. McCloy, R.C.A.F.; Georgina P. MacLatchey to

Lieut. Reay M. Black, R.C.E.; Nursing Sister Jane C. Jacobs (1941) R.C.A.M.C. to Surgeon-Lieut. Paul G. Schwager, R.C.N.V.R.; I. McCausland (1941) to Percy Fitzgerald; Nursing Sister Gertrude Lake, R.C.A.M.C. to Capt. J. Leishman, R.C.A.M.C.

Royal Victoria Hospital:

The Halifax branch of the Alumnae Association of the Royal Victoria Hospital held a meeting recently at the home of Marjorie Evans Cooper (1932). Among the members present were Electa MacLennan (1932), Elma Hamilton Dawson (1934), Marjorie Young Grant (1937), Constance Lambertus (1934), Jean Dunning (1929), Helen Butcher (1939), Frances MacDonald (1938), Lucille Smith Reid (1928), Mildred Colpitts Reid (1923), Berta Colwell Crosby (1923), H. G. McKenzie, Lenta Hall (1924), Joyce MacDonald (1934), Frances Vassie Jost (1935), Jean Church (1938), Edith Hennigar (1930), Christine McCormack Genn (1925), Helen Robertson (1931), Helen MacPhee, R.C.A.M.C., and Rae Fellowes, R.C.N.V.R.

The Alumnae Association in Montreal continues very active turning over 6150 dressings a week to the Red Cross and sea boot socks and other woollen comforts to the Overseas Parcel League and Mine Sweepers Auxiliary.

The following marriages have recently taken place: Nursing Sister Ann Hudson (No. 1 Neurological Hospital) to Capt. Thomas, R.C.E.; Madge McLaughlin (1938) to Lieut. Merrill Cannon Trotter, R.C.A.M.C.

McGill School for Graduate Nurses:

Visitors to the School during Christmas included Alice G. Nicolle (P.H.N., 1933) who is on the staff of the Protestant Episcopal Church Hospital in Philadelphia, and Katherine G. McLean (T. & S., 1941) who is now on duty with the R.C.A.M.C. Nursing Service.

St. Mary's Hospital:

The Alumnae Association of St. Mary's Hospital recently held a regular meeting at which Dr. Gerrie was the guest speaker. He gave an interesting talk on plastic surgery.

ESSENTIALS OF NURSING

By Helen Young, R.N., Director of Nursing, Columbia-Presbyterian Medical Center, and Associates. Eleanor Lee, R.N., A.B., Editor. 609 Pages, illustrated. $3.50.

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In order to comply with certain regulations arising out of wartime conditions, we regret that this announcement must *temporarily* be withdrawn from the pages of *The Canadian Nurse.*

C. M. Powell, R. N., Director

. . . OFF . . . DUTY . . .

A former leader of a certain political party made an arresting statement the other day . . . He suggested that what we hear over the radio has a most profound effect upon our mental processes . . . and therefore is a potent factor in creating public opinion . . . With all due deference to so distinguished an authority, we think he is mistaken . . . To begin with, we aren't a bit sure that pure thought bears any close relation to public opinion . . . which seems to us to be influenced by all sorts of emotional responses . . . some of them downright irrational . . . We admit that the radio tries to enlighten us about many things . . . but all too often we find ourself developing what the psychologists call a resistive attitude . . . This happens even in the realm of music where we find it easy to be receptive . . . Meekly sitting at the feet of Mr. Deems Taylor . . . we do our level best to give a sympathetic hearing to the composers of modern music . . . and on a recent Sunday afternoon we dutifully set out to listen to a very modern composition by Ernst Krenek . . . played by the New York Philharmonic Symphony Orchestra . . . under the direction of Dimitri Mitropolous . . . The title was "I wonder while I wander" . . . so we fondly hoped for soft and soothing strains in a pastoral setting . . . When it was too late to do anything about it . . . we learned that, in the composer's own words, "the work is written in the aggressive idiom of atonality whose main organizing agency is elemental rhythmic force" . . . If we had known this beforehand, we should have been better prepared for something which sounded like a locomotive going up a steep grade . . . dragging a train of flat cars loaded with scrap metal . . . However, we held on grimly . . . and waited for Mr. Deems Taylor to explain the deceptively lyric title that had so sadly misled us . . . All of a sudden the tumult ceased . . . and it was announced that there would be a brief interruption . . . so that we might hear from Captain Edward Rickenbacker . . . who would speak about his rescue . . . from a collapsible rubber boat adrift on the Pacific Ocean . . . He told us the simple and moving story of those days and nights of suffering and despair . . . of how a young member of the crew of his airplane had died in his arms . . . of the prayer that he was certain had brought the rains that quenched their burning thirst, the seagull that was the food without which they would have perished . . . Of all the flood of oratory we have heard over the radio . . . this seemed to us to be the most spontaneous utterance we had ever listened to . . . he told us what had happened to him with the directness of a child . . . he didn't ask us to believe it . . . he didn't seem to care whether we did or not . . . there it was, take it or leave it . . . to him it was an authentic miracle . . . The deep voice trembled a little as the story ended . . . and we were back in Carnegie Hall . . . where Ernst Krenek was still wrestling with atonality and elemental rhythmic force . . . But in contrast to what we had just heard, they sounded like a political speech . . . full of sound and fury, signifying nothing . . .—E. J.

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Greater Vancouver District

Vancouver Chapter, Registered Nurses Association of British Columbia

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MANITOBA

Manitoba Association of Registered Nurses

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NEW BRUNSWICK

New Brunswick Association of Registered Nurses

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NOVA SCOTIA

Registered Nurses Association of Nova Scotia

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ONTARIO

Registered Nurses Association of Ontario

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PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

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QUEBEC

Association of Registered Nurses of the Province of Quebec (Incorporated, 1920)

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SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

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Regina Registered Nurses Association

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Alumnae Associations

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A.A., Calgary General Hospital, Calgary

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A.A., Edmonton General Hospital, Edmonton

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A.A., St. Paul's Hospital, Vancouver

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A.A., Vancouver General Hospital, Vancouver

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MANITOBA

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A.A., Children's Hospital, Winnipeg

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NEW BRUNSWICK

A.A., Saint John General Hospital, Saint John

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NOVA SCOTIA

A.A., Glace Bay General Hospital, Glace Bay

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ONTARIO

A.A., Belleville General Hospital, Belleville

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A.A., Brantford General Hospital, Brantford

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A.A., Brockville General Hospital, Brockville

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A.A., Public General Hospital, Chatham

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A.A., St. Joseph's Hospital, Chatham

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A.A., Cornwall General Hospital, Cornwall

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A.A., Guelph General Hospital, Guelph

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A.A., St. Joseph's Hospital, Guelph

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A.A., Hamilton General Hospital, Hamilton

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A.A., St. Joseph's Hospital, Hamilton

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A.A., Kingston General Hospital, Kingston

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